

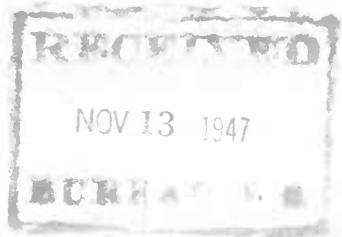
159
10520

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH + Death
Reg. Dist. No. 302

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:		2. USUAL RESIDENCE OF MOTHER:	
County Washington		State Maryland	
City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)		County Washington	
Street address, hospital, or institution: 25 Bellevue Ave.		City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)	
Length of mother's stay in County (How many years, or months, or days. SPECIFY WHICH)		Street No. 25 Bellevue Ave. (If RURAL give LOCATION)	
3. Name of child Armel		4. Date of birth Nov. 11, 1947 Hour. 9 A.M.	
5. Sex Female 6. Twin or triplet		7. No. of weeks pregnancy 6 months	
FATHER OF CHILD			
8. Full name Powell Page Armel		MOTHER OF CHILD	
9. Color White		12. Full maiden name Bellie Anna Susan Wolf	
10. Age at time of this birth 38 yrs.		13. Color White	
11. Usual occupation Engineer		14. Age at time of this birth 26 yrs.	
16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 2 (b) How many other children were born alive but are now dead? 0 (c) How many other children were born dead? 0			
17. Did child die before labor? No During labor? No			
18. Pregnancy, complications of.....			
19. Labor: (a) Complications of..... (b) Induced?			
20. (a) Was there an operation for delivery? No (Yes or No) (b) State all operations, if any.....			
(c) Did child die before operation? During operation?			
23. (a) Burial (b) Date thereof 11-12-47 (Burial, cremation or removal) (c) Cemetery or cemetery Funkstown Md.			
24. (a) Funeral director Scott F. Minnich & Son (b) Address Hagerstown Md.			
25. (a) Nov. 11, 1947 (b) Death (Date rec'd by registrar) (Registrar)			
26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me. Health Officer, per.....			

* See Instruction C on stub.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly
is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Victor Miller

10380

13/a

CERTIFICATE OF DEATH

Reg. Dlat. No. 302

1. PLACE OF DEATH:

County Washington

City or town Maugansville

(If outside city or town limits, write RURAL and give nearest town)

9 Years

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Main St.

How long in hospital or institution? --

3. (a) FULL NAME

WILLSON F. ARNDT

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

--

6.(b) Name of husband or wife.....

6.(c) If alive, give age -- years

7. Birth date of deceased (mo. day, yr.) April 6 1863

8. AGE: Years Months Days It less than one day

84 6 29 hrs. min.

9. Birthplace Allentown Lehigh Co. Pa. (Town, county, and state)

10. Usual occupation Broom Man ufacturer

11. Industry or business Retired

MOTHER FATHER 12. Name No Record

13. Birthplace No Record

14. Maiden name No Record

15. Birthplace No Record

16. Informant J.P. Martin

Address Maugansville Md.

17. Burial Date thereof 11/7/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Reiffs Mennonite Cemetery

Location Near Gearfoss Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Date rec'd by registrar Nov. 6. 1947

Registrar Chester Barasch

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Maugansville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5 1947 at 4:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1 - 1947 to 1947 and that I last saw him alive on 11/4 1947

Immediate cause of death

chronic Endo Carditis
" nephritis.
arterio sclerosis -
Cystitis.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

John Miller

23. SIGNATURE

M. D.

Address

Date signed 11/4 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

45c+

10381-302
Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: WashingtonCounty HagerstownCity or town (If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 15 YearsHospital, institution, or street address where death occurred: 130 Williams Avenue

How long in hospital or institution?

3. (a) FULL NAME Mary Josephine Arnold4. Sex Female 5. Color or race Negro 6. (e) Single, married, widowed, or divorced Married6. (b) Name of husband or wife John Arnold7. Birth date of deceased (mo., day, yr.) August 10, 19088. AGE: 39 Years 3 Months 5 Days If less than one day hrs. min.9. Birthplace Burkittsville, Md
(Town, county, and state)10. Usual occupation Domestic11. Industry or business William Smathers12. Name William Smathers13. Birthplace Burkittsville, Md14. Maiden name Harriet Brown15. Birthplace Burkittsville, Md16. Informant Miss Lina ButlerAddress 130 Williams Avenue,Burial Pineview Cemetery

(Burial, cremation, or removal. Which?)

Cemetery or crematory Pineview CemeteryLocation Williamsport, Md18. Funeral director William J. DawsonAddress 291 Frederick St. Maryland19. Date rec'd by registrar Nov. 7, 1947(Date rec'd by registrar) 1947 Death Power

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town (If outside city or town limits, write RURAL and give nearest town)Street No. 130 Williams Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6th 1947 at 12 M.A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 5th 1947 to Nov. 6th 1947 and that I last saw her alive on Oct. 24th 1947.Immediate cause of death Squamous Carcinoma - floor of mouthDURATION 8 wks?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations as above.Date of op. Oct. 15 1947

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

Where did injury occur? (City or town) (County) (State)

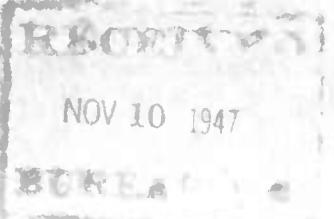
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Reverend John L. Johnson

M. D. or other

Address 159 W. Washington St. Hagerstown, Md. Date signed 11/7/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10382

CERTIFICATE OF DEATH

Reg. Diat. No. 307

Dr. Clark

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Washington
 City or town... Park Hall - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 mo.Hospital, Institution, or street address where death occurred: Boonsboro Md. R. 2How long in hospital or institution? at Home

3. (a) FULL NAME

Williams Washington

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

MaleWhiteWidowed6. (b) Name of husband or wife Anna Mary Beachley

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

February 22 - 1868

8. AGE:

Years

Months

Days

if less than one day

79 8 14

hrs.

min.

9. Birthplace

Reno Fred. Co. Md.

(Town, county, and state)

10. Usual occupation

Retired Farmer

11. Industry or business

MOTHER FATHER

John Henry Beachley

13. Birthplace

Reno Fred. Co. Md.

14. Maiden name

Elizabeth Summers

15. Birthplace

Wolfville Fred. Co. Md.

16. Informant

C. E. Beachley

Address

3001 Graham Blvd. Pittsburgh 21. Penna.

17. Burial

Date thereof Nov. 9 - 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

W.W. & Bast & Sons

Address

Boonsboro Md.

19. Date rec'd by registrar

19-7

Mrs. Katherine Chapman

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Park Hall - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Boonsboro Md. R. 2
(If rural, give LOCATION)

2.(a) If veteran, name war

No.

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 61947 at 9th A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 26 1947 to Nov. 6 1947and that I last saw him alive on Nov. 2 1947

Immediate cause of death

Chronic Myocarditis

DURATION

2yr. 3 mosDue to Chronic nephritis"

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

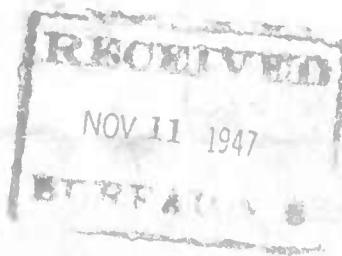
Means of injury

injured at work?

23. SIGNATURE Gilbert Wade M.D.

M. D. or other

Address Boonsboro Md.Date signed 11/7/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10383

CERTIFICATE OF DEATH

Reg. Dist. No. *468 X**304*

1. PLACE OF DEATH:

County *Washington*City or town *Hancock*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? *About 40 yrs.*

Hospital, institution, or street address where death occurred:

How long in hospital or Institution?

3. (a) FULL NAME

Richard Roman Bishop.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male *White* Married6. (b) Name of husband or wife *Addie E. Smith**Bishop*6. (c) If alive, give age *58* years

7. Birth date of deceased (mo., day, yr.)

May 30, 1886

8. AGE:

Years *61* Months *5* Days *6* If less than one day

9. Birthplace

Washington Co., Md.
(Town, county, and state)

10. Usual occupation

Railroader

11. Industry or business

12. Name *Denton Bishop*13. Birthplace *Maryland*14. Maiden name *Ellen Haw*15. Birthplace *Maryland*16. Informant *Mrs. Addie Bishop*Address *Hancock, Md.*

17. Burial

Date thereof *Nov. 9, 1947*
(Burial, cremation, or removal. Which?)
(month) (day) (year)Cemetery or crematory *Parkhead Evan Church Cem.*Location *U.S. Route 40 - 8 mi. East of Hancock*18. Funeral director *Charles R. Bast*Address *Hancock, Maryland*19. *11-8-47*

(Date rec'd by registrar)

J. J. Heller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland*County *Washington*City or town *Hancock*

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

705-05-9185

MEDICAL CERTIFICATION

20. DATE OF DEATH *November 5 1947* at *10:45 A.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *August 25 1947* to *November 5 1947*and that I last saw him alive on *OCTOBER 14 1947*

Immediate cause of death

*Carcinoma Pancreas
with metastasis*

DURATION

?

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations *Same*Date of op. *SEPT. 12 1947*Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

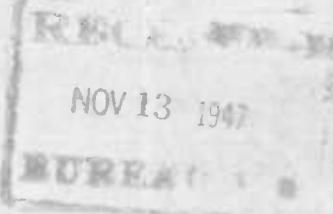
Meane of Injury

Injured at work

23. SIGNATURE *Audie Robert Cohen*

M. D.

Address *Clear Spring, Md.* Date signed *Nov. 8 1947*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

19384

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTONCity or town HAGERSTOWN

(If outside city or town limits, write RURAL and give nearest town)

70 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:

WASHINGTON COUNTY HOSPITAL

How long in hospital or institution?

1 WEEK

3. (a) FULL NAME

DANIEL DAVID BOWARD

3. (b) Social Security Number

215-07-4252

4. Sex

5. Color or race

8.(a) Single, married, widowed, or divorced

MALE

WHITE

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) JUNE 6, 1872

6.(c) If alive, give age years

8. AGE: Years Months Days It less than one day

75 4 29 hrs. min.

9. Birthplace FALLING WATERS, BERKLEY, W. VA.

(Town, county, and state)

10. Usual occupation SICK WEAVER

11. Industry or business SICK MILL

12. Name DENTON BOWARD

13. Birthplace HAGERSTOWN, MD.

14. Maiden name LAURA RIDENOUR

HAGERSTOWN, MD.

15. Birthplace HAGERSTOWN, MD.

16. Informant Raphael Boward (nephew)

Address 321 S. Cannon Ave.

Burial

Date thereof 11/17/47
(month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown, Md.

18. Funeral director Woodford T. Horment

Address Hagerstown, Md.

Nov. 6, 1947

19. (Date rec'd by registrar) 1947

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTONCity or town HAGERSTOWN

(If outside city or town limits, write RURAL and give nearest town)

Street No. 519 S. POTOMAC ST.

(If rural, give LOCATION)

2.(a) Is veteran, name war

NON-VET

MEDICAL CERTIFICATION

2D. DATE OF DEATH

11/15 1947 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10/1 - 1947 to 11/15 1947

and that I last saw him alive on 11/15 1947

Immediate cause of death

chronic pulmonary heart

" nephritis.

Due to arterio sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

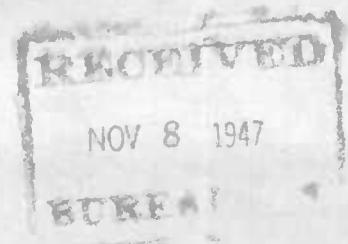
Means of Injury

Injured at work?

23. SIGNATURE

V. Boward M. D. or other

Address Hagerstown, Md. Date signed 11/6 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10385

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, Institution, or street address where death occurred:

328 W. Howard Street

How long in hospital or institution?

3. (a) FULL NAME

William H. Bowers

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Lousia K. Bowers

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 8, 1872

8. AGE: Years	Months	Days	It less than one day
75	1	19	hrs. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual occupation Retired Tinner

11. Industry or business Unknown

MOTHER FATHER	12. Name
	Unknown

MOTHER	13. Birthplace
	Unknown

FATHER	14. Maiden name
	Unknown

MOTHER	15. Birthplace
	Unknown

16. Informant Mrs. Lousia K. Bowers

Address 328 W. Howard St. Hagerstown, Md

17. Burial Date thereof Dec. 1, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Maryland

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

19. Dec. 11, 1947 *Philip J. McLean*
(Date rec'd by registrar) *Philip J. McLean* Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 328 West Howard Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 27 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 6 1947 to Nov. 27 1947

and that I last saw him alive on Nov. 14 1947

Immediate cause of death Hypertensive Heart Disease

DURATION 18 hrs.

Due to

Due to

Other conditions Pneumonia

18 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

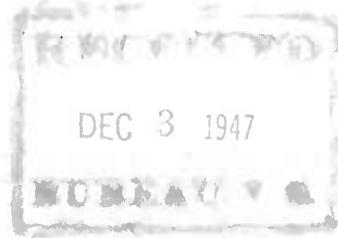
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE *Philip J. McLean* M. D. or other

Address 157 W. Washington St. Date signed Dec. 1/28/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117b

10389

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:
 County Washington County
 City or town Hagerstown, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? 10-9-47 to 11-3-47

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Md. County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1029 Concord St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

WILLIAM DAVID DAUGHERTY

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		
Male	White	Married		
6.(b) Name of husband or wife Emma Schuyler Daugherty				
7. Birth date of deceased (mo., day, yr.) March 18 1862				
8. AGE:	Years 85	Months 7	Days 15	It less than one day hrs. min.
9. Birthplace Adams County Pa. (Town, county, and state)				
10. Usual occupation Farmer				
11. Industry or business				
FATHER	12. Name David Daugherty			
MOTHER	13. Birthplace Adams Co. Pa.			
14. Maiden name Eliza J. Herbst				
15. Birthplace Adams Co. Pa.				
16. Informant Alva L. Stonesifer				
Address Orrtanna Pa.				
17. Burial Date thereof Nov. 6 1947 (Burial, cremation, or removal. Which?)				
Cemetery or crematory Union Cemetery				
Location Fairfield, Pa.				
18. Funeral director H. L. Gillison				
Address Fairfield Pa.				
19. (Date rec'd by registrar) Nov. 6 1947 - G. H. Bowes			Registrar	
*(Date rec'd by registrar)				

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH	November 2 1947 at 6:05 AM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1947 to November 2 1947 and that I last saw him alive on Oct 31 1947	
and immediate cause of death	
Obstinate abdominal pain	
Due to Malnutrition	
Duration 1 week	
Due to Old duodenal ulcer with obstruction	
Duration 4 months	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Duodenal ulcer with obstruction due to adhesions of op. 15 Oct 47

Autopsy results but performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

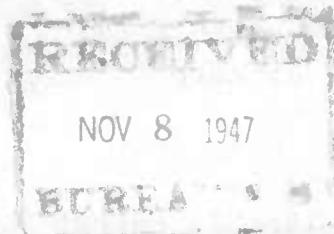
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Layman M.D. M. for other
Address 1003 Garrison St. Bldg. 1947
Date signed 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

872

10386

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

14 Randolph Avenue

How long in hospital or institution?

3. (a) FULL NAME

Eliza Jacques Brenner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Divorced

8. (b) Name of husband or wife

8. (c) If alive, give age... years

7. Birth date of deceased (mo. day, yr.)

April 17, 1892

8. AGE:

Years
55Months
6Days
22

If less than one day

hrs.

min.

9. Birthplace

Clearspring, Maryland

(Town, county, and state)

10. Usual occupation

Retired Stenographer

11. Industry or business

MOTHER FATHER

12. Name

Samuel G. Jacques

13. Birthplace

Indian Spring, Maryland

14. Maiden name

Sally M. Kreps

15. Birthplace

Clearspring, Maryland

16. Informant

Mrs. S. G. Jacques

Address

Hagerstown, Maryland

17. Burial

Date thereof 11-10-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Smithsburg Cemetery

Location

Smithsburg, Maryland

18. Funeral director

C. M. Suter & Sons

Address

Hagerstown, Maryland

19. No. 8. 1947

(Date rec'd by Registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Randolph Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

11/8

1947 72

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 18 47 to 11/8

1947

and that I last saw him alive on 11/7 -

1947

Immediate cause of death

Multiple Sclerosis 6-7 years

Chronic Euedocarditis

Due to (Palpular)

Due to

Other conditions

O

(Include pregnancy within 3 months of death)

Major findings of operations

Data of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

131 W. WASHINGTON ST.

HAGERSTOWN, MD.

23. SIGNATURE DR. VICTOR D. MILLER.

Address 131 W. WASHINGTON ST.

Date signed 11/8-1947

WYOMING STATE DEPARTMENT OF HIGHWAYS

Storage of available energy

CERTIFICATE OF PEE

1238 TAUBER 4
(1400-193)

J. FACE OF DEATH

Chlorophyll-a concentration was measured at the surface of the water column at each sampling site.

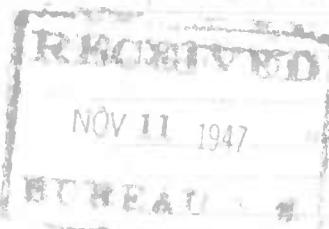
1991-2000: 61650 students < 100% family income below poverty level

第10章

1980-1981
Yearly average
1980-1981

4.3.3. Decision Function

OVIDE (7), 8



— ፳፻፲፭፻፭፻፭ .፭

Singer Index

Friend to friend 17

HEI

878

第十一章

SEARCHING FOR THE

1450016157 / 04

104 [404-405] (2000)

2024 RELEASE UNDER E.O. 14176

• 10120 16344 61

© 2008

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Linson

10387

Reg. Distr. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157a

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, Institution, or street address where death occurred:

Washington county Hospital

How long in hospital or institution? 6 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 277 So. Potomac St.

(If rural, give LOCATION)

None

3. (a) FULL NAME

LESTER DOUGLAS BREWER

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.)

May 14 1947

8. AGE:

Years	Months	Days	If less than one day
5	21	hrs.	min.

9. Birthplace Hagerstown Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business --

12. Name William E. Brewer

13. Birthplace Brooklyn New York

14. Maiden name Helen Barkdoll

15. Birthplace Hagerstown Md.

16. Informant William E. Brewer

Address Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11/7/47
(month) (day) (year)

Rose Hill Cemetery

Cemetery or crematory

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

Nov. 7, 1947
(Date rec'd by registrar)

Registrar

23. SIGNATURE

Elizabeth L. Linson
M. D.

Address 214 N. Potomac St. Date signed 11-6-47

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

P

20. DATE OF DEATH November 5 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 14, 1947, to Nov. 6, 1947,

and that I last saw him alive on Nov. 5, 1947.

Immediate cause of death

Respiratory failure

DURATION

Due to Hydrocephalus

Due to

Other conditions Meconium aspiration

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Hydrocephalus + meconium aspiration

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

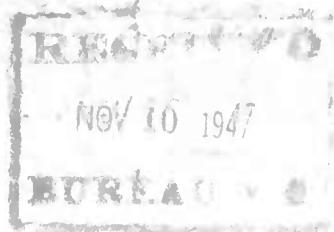
Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age < is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

838

10388

Reg. Dist. No.

306

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Washington
 County: District of Columbia
 City or town: Near L'Anetown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 yrs.

Hospital, Institution, or street address where death occurred: -

How long in hospital or institution? -

3. (a) FULL NAME

Joseph A. Brown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife not living

7. Birth date of deceased (mo., day, yr.) 3-1864 8.(c) If alive, give age not living years

8. AGE: Years 83 Months 2 Days 29 If less than one day - hrs. - min.

9. Birthplace Near Fayville Fred Co Md
 (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business farmer

12. Name George F. Brown

13. Birthplace Near Fayville Fred Co Md

14. Maiden name Mary Busnard

15. Birthplace Near Fayville Fred Co Md

16. Informant Frank P. Brown

Address L'Anetown Md

17. Burial Date thereof 11-4-1947
 (Burial, cremation, or removal. Which?) Burial (month) (day) (year)

Cemetery or crematory Smithsburg

Location Smithsburg Fred Co Md

18. Funeral director Geo W Hooper

Address Smithsburg Md

19. Nov 3 1947 Geo W Ferguson
 (Date rec'd by registrar)

Registrar Geo W Ferguson

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State: Maryland County: Washington

City or town: Near L'Anetown (If outside city or town limits, write RURAL and give nearest town)

Street No.: nove (If rural, give LOCATION)

2.(a) If veteran, name war none

3. (b) Social Security Number none

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 2 1947 at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 2 1947 to Nov 2 1947

and that I last saw him alive on Nov 2 1947

Immediate cause of death

General infarction of the heart DURATION 10 min.

Due to Arteriosclerosis 10 yrs

Due to Arteriosclerosis

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

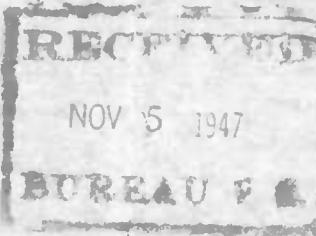
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE G. G. Kohler M. D. or other

Address Smithsburg Date signed Nov 3 1947





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10390
169

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington

City or town Williamsport

(If outside city or town limits, write RURAL and give nearest town)

5 Hours

How long in above place of death?

Hospital, institution, or street address where death occurred:

Western Md.R.R. line Byron's Tannery

How long in hospital or institution?

3. (a) FULL NAME

Bernard Glen Davis

3. (b) Social Security Number

217-09-9500

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Nellie Mae Davis

7. Birth date of deceased (mo., day, yr.)

May 14, 1919

27

6.(c) If alive, give age years

8. AGE:

Years
28Months
6Days
7If less than one day
.....hrs.min.

9. Birthplace Fairplay, Washington, Maryland

(Town, county, and state)

10. Usual occupation

Conductor & extra brakeman

11. Industry or business

Western Md. Railroad

12. Name

Harry Raymond Davis

13. Birthplace

Williamsport, Md. RFD#1

14. Maiden name

Mary K. Miller

15. Birthplace

Fairplay, Maryland

16. Informant

Mary K. (Miller) Davis

Address

Fairplay, Maryland

17. Burial

Date thereof Nov. 24, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Greenlawn Cemetery

Location

Williamsport, Maryland

18. Funeral director

Mrs. Edith V. Leaf

Address

Williamsport, Maryland.

19. Nov. 24

1947

Mrs. E. Lee McElroy

Registrar

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Halfway

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2113 Gay Street

(If rural, give LOCATION)

2.(a) If veteran, name war World War II

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov/21/47

19. 11:45A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....to.....

and that I last saw h.....alive on.....

19.....

Immediate cause of death.....

19.....

crushed abdomen

Due to crushed vertebral column

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....accident Date of.....11/21/47

Where did injury occur.....Williamsport Wash. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) at work West. Md. RR tra

Means of injury caught between tool and work? REEDORS

WASH. CO., MD.

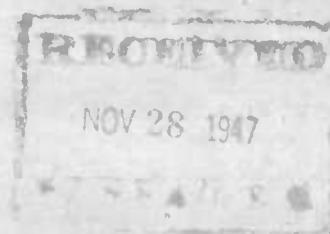
23. SIGNATURE

Robert Wells

DEPUTY MEDICAL EXAMINER

Hagerstown, Md.

WASH. CO., MD.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61
10391
Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown R # 6

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Years

Hospital, Institution, or street address where death occurred: Leitersburg Pike

How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown R # 6
(If outside city or town limits, write RURAL and give nearest town)

Street No. Leitersburg Pike

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME

MRS. MARY ANN DEIBERT

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Charles H.

7. Birth date of deceased (mo., day, yr.) June 11 1866

8. AGE: Years Months Days If less than one day
81 4 26 hrs. min.9. Birthplace St. James Wsh. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

MOTHER FATHER 12. Name Isaac Rowland

13. Birthplace St. James Md.

14. Maiden name Ellen Mongan

15. Birthplace St. James Md.

16. Informant Mrs. Charlotte White

Address Hagers town Md. R # 6

17. Burial Date thereof 11/9/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 8. 47 - Glass Flowers
(Date rec'd by registrar)

Registrar

3.(b) Social Security Number

None

MEDICAL CERTIFICATION A

20. DATE OF DEATH November 7 47 at 4.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 18 47, to November 7 19 47
and that I last saw her alive on Nov. 6 19 47

Immediate cause of death

Coronary arteriosclerotic
Heart Disease

DURATION

4 yrs.

Due to

Due to

Other conditions Diabetes mellitus

6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

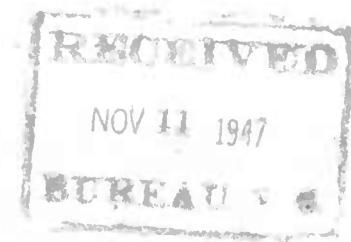
Injured at home, farm, industry, public place (where?)

Mssns of injury Injured at work?

23. SIGNATURE Salton M. Welty M.D.

D. or other

Address 998 Potomac Dr. Hagerstown Date signed 11-7-47



Evidence for the change of

Given name is shown on

114 1/7/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

10392

302

Reg. Dist. No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: Washington
County _____
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town) 8 days
How long in above place of death? 8 days
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 8 days

3. (a) FULL NAME EMORY D.
Henry W. Diehl Sr.

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Irene D. Diehl
7. Birth date of deceased (mo., day, yr.) August 12, 1879 69 years
6.(c) If alive, give age 69 years
8. AGE: Years Months Days If less than one day
68 3 7 hrs. min.
9. Birthplace Fulton Co. Pa.
(Town, county, and state)

10. Usual occupation Retired
11. Industry or business None
12. Name Samuel Diehl
13. Birthplace Fulton Co. Pa.
14. Maiden name Fannie Heff
15. Birthplace Fulton Co. Pa.
16. Informant Mrs. Irene Diehl
Address McConnellsburg Pa.

17. Burial Date thereof 11-22-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Fulton Co. Pa.

18. Funeral director Scott F. Minnich & Son
Address Hagerstown Md.
19. Nov. 20, 1947 - *Elsie Bowers*
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
a. State _____ Fulton
City or town _____ McConnellsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION
20. DATE OF DEATH November 19 47 at 4:20p.m.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 11 1947 to Nov. 19 1947
and that I last saw him alive on Nov. 19 1947

Immediate cause of death UREMIA ACUTE-
Cause undetermined (1/47 also)
Due to Cerebral arterio
oclerosis

Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. same.

Autopsy results Same.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of _____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE *Audie Robert Cohen*
M. D. *Crown Point Md*
Address *Clear Spring Md* Date signed *11-20-47*



Dr. Wm Layman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10393

Reg. Dist. No. 8A57

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington
City or town Boonsboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Days

Hospital, institution, or street address where death occurred:

Guilford Convalescent Home

How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Boonsboro R # 1
(If outside city or town limits, write RURAL and give nearest town)

Street No. State Road

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME

MRS. ANNA HAMBURG DINSMORE

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Wm A. Dinsmore

7. Birth date of deceased (mo. day, yr.) March 23 1873

8. AGE: Years Months Days If less than one day
74 7 29 hrs. min.9. Birthplace Hagerstown Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Abram Hamburg

13. Birthplace Cascade Md.

14. Maiden name Evaline Cover

15. Birthplace Thurmont Md.

16. Informant W. Earl Dinsmore

Address Hagerstown Md.

17. Burial Date thereof 11/25/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 24, 1947 John R. Bart
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 3 1947 to Nov 22 1947

and that I last saw her alive on Nov 18 1947

Immediate cause of death

Hypertensive Cardio-
vascular disease

DURATION

?

Due to

Due to

Other conditions Chronic Pulmonary Tuberculosis

?

Tuberculosis Peritonitis

2 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

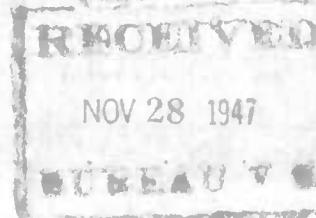
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John R. Bart M.D. or other
108 Patterson St. Baltimore, Md. Date signed 24 Nov 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Wells

10394

Reg. Dist. No. 302

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Years

Hospital, institution, or street address where death occurred:

900 Concord St.

How long in hospital or institution? —

3. (a) FULL NAME

GEORGE DOMINICK

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widower

6.(b) Name of husband or wife

Maria

6.(c) If alive, give age. — years

7. Birth date of deceased (mo., day, yr.)

August 13, 1877

8. AGE: Years

70

Months

3

Days

16

If less than one day

hrs.

min.

9. Birthplace

San Luca Italy

(Town, county, and state)

10. Usual occupation

Trackman

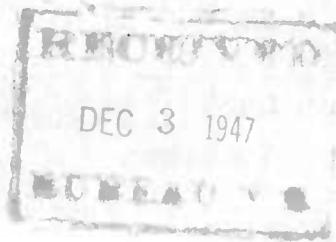
11. Industry or business

Western Maryland Rail Road

MOTHER

FATHER

Bastario Dominick



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

10395

CERTIFICATE OF DEATH

Reg. Dist. No. 305

MV

1. PLACE OF DEATH:

Washington
County.....Rural :- MAPLEVILLE
(If outside city or town limits, write RURAL, and give nearest town)

How long in above place of death? Auto accident

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Kenneth Ward Dyche

4. Sex male | 5. Color or race white | 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Lyda Jane Kitchen Dyche

7. Birth date of deceased (mo., day, yr.) August 16, 1922

8. AGE: Years 25 | Months 3 | Days - | If less than one day hrs. min.

9. Birthplace Martinsburg, Berkeley Co., W. Va.
(Town, county, and state)

10. Usual occupation Plant operator

11. Industry or business Dairy

12. Name Earl E. Dyche

13. Birthplace Berkeley Springs, W. Va.

14. Maiden name Lara Elva Ward

15. Birthplace Mineral Co., W. Va.

16. Informant Lyda J. K. Dyche

Address Martinsburg, W. Va.

17. Burial Date thereof 11-18-47
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Rosedale Cemetery

Location Martinsburg, W. Va.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown, Md.

19. Nov. 16. 1947 John D. Best
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Berkeley

City or town Martinsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 516 Buxton St.

2. (a) If veteran, name war World War II

3. (b) Social Security Number

232-26-6380

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16. 1947 1:20A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19. to 19.

Immediate cause of death.

Fractured skull

Due to crushed chest

Due to (Suffocation)
and shock

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Autopsy results No - spinal Fluid for alcohol Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. accident Date of Nov. 16/47
Where did injury occur? Mapleville Wash. Md.

(City or town) (County) (State) Route 466

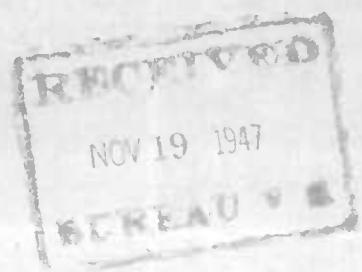
Injured at home, farm, industry, public place (where?) Fell out of car & auto fell on body

Means of injury Injested at work?

23. SIGNATURE S. Robert Wells DEPUTY MEDICAL EXAMINER

WASH. CO., MD. M. D. mother

Address Hagerstown, Md. Date signed Nov. 16/47



MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The copy not age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1936

938

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital
3 days

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 229 Frederick St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mary K. Fahrney

3.(b) Social Security Number

None

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widowed

6.(b) Name of husband or wife

Clayton Fahrney

7. Birth date of deceased (mo., day, yr.)

Jan. 15, 1865

6.(c) If alive, give age.....years

8. AGE:

Years
82Months
9Days
27

less than one day

hrs. min.

9. Birthplace

Franklin Co. Penna.

(Town, county, and state)

10. Usual occupation

Home duties

11. Industry or business

12. Name Henry Cleverstone

13. Birthplace Greencastle, Pa.

14. Maiden name Catherine Starry

15. Birthplace Waynesboro, Pa.

16. Informant Mrs. J. A. Forsythe

Address 147 E. Baltimore St. Hagerstown,

17. Burial

Date thereof Nov. 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19. Nov. 13. 1947

Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10, 1947 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19, 42, to November 10, 1947.

and that I last saw her alive on November 10, 1947.

Immediate cause of death

Bronch- pneumonia

DURATION

4 days

Due to

Due to

Other conditions Chronic Myocarditis

5 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

MD.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 148 W. Washington Street Date signed Nov 13, 1947

RECEIVED

NOV 15 1947

STRA

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

93d 10397

CERTIFICATE OF DEATH

Reg. Dist. No. 302

PLEASE WRITE PLAINLY, WITH ENFADING INK. Supply every item of information carefully. In case of death of newborn infants give residence of mother.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

232½ North Potomac Street

How long in hospital or institution?

3. (a) FULL NAME

Mary Kate Fechtig

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
--------	------------------	--

Female White Widow

6. (b) Name of husband or wife Charles C. Fechtig

7. Birth date of deceased (mo. day, yr.) August 14, 1852

8. AGE: Years Months Days If less than one day
95 3 1 hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

MOTHER FATHER
12. Name Joseph Smith

13. Birthplace Greencastle, Pa.

14. Maiden name Elizabeth Bragunier

15. Birthplace Washington County, Md.

16. Informant Mrs. Naomi Hearon

Address Hagerstown, Maryland

17. Burial Data thereof 11-18-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Paul Cemetery

Location Western Pike,

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

Nov. 18. 1947 Chaff Bowers
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 232½ North Potomac Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

Nov/15/47

20. DATE OF DEATH Nov. 18. at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 34 to Sept/18, 1947
and that I last saw her alive on Sept/20, 1947

Immediate cause of death

Chr. myocarditis

Due to acute ventricular fibrillation

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. Rohr & Mulls M.D.

M. D. or

Date signed Nov/17/47

MARYLAND STATE DEPARTMENT OF HEW

8421 M. Charles St., Baltimore

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County _____

City or town _____

State _____

Country _____

Other _____

2. USES REG
(List names)

3. DATE OF DEATH

4. PLACE OF DEATH

5. OCCUPATION

6. AGE

7. GENDER

8. RACE

9. RELIGION

10. NATIONAL ORIGIN

11. INSTITUTION OR COMPANY

12. NAMES

13. BIRTHPLACE

14. MIDDLE NAME

15. JEWISH

16. MUSLIM

17. ADDRESS

18. GENERAL DESCRIPTION

19. SPECIALTY OR ELEMENTS

20. FOCUSES

21. ADDRESS

22. ADDRESS

23. ADDRESS

24. ADDRESS

25. ADDRESS

26. ADDRESS

27. ADDRESS

28. ADDRESS

29. ADDRESS

30. ADDRESS

31. ADDRESS

32. ADDRESS

33. ADDRESS

34. ADDRESS

35. ADDRESS

36. ADDRESS

1. PLACE OF DEATH:
City or town _____
State _____
Country _____
Other _____2. USES REG
Occupation _____
Name _____
Address _____
City _____ State _____ Zip _____3. DATE OF DEATH:
Year _____ Month _____ Day _____4. PLACE OF DEATH:
Name _____ Address _____ City _____ State _____ Zip _____5. OCCUPATION:
Name _____ Address _____ City _____ State _____ Zip _____6. AGE:
Name _____ Address _____ City _____ State _____ Zip _____7. GENDER:
Name _____ Address _____ City _____ State _____ Zip _____8. RACE:
Name _____ Address _____ City _____ State _____ Zip _____9. RELIGION:
Name _____ Address _____ City _____ State _____ Zip _____10. NATIONAL ORIGIN:
Name _____ Address _____ City _____ State _____ Zip _____11. INSTITUTION OR COMPANY:
Name _____ Address _____ City _____ State _____ Zip _____12. NAMES:
Name _____ Address _____ City _____ State _____ Zip _____13. BIRTHPLACE:
Name _____ Address _____ City _____ State _____ Zip _____14. MIDDLE NAME:
Name _____ Address _____ City _____ State _____ Zip _____15. JEWISH:
Name _____ Address _____ City _____ State _____ Zip _____16. MUSLIM:
Name _____ Address _____ City _____ State _____ Zip _____17. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____18. GENERAL DESCRIPTION:
Name _____ Address _____ City _____ State _____ Zip _____19. SPECIALTY OR ELEMENTS:
Name _____ Address _____ City _____ State _____ Zip _____20. FOCUSES:
Name _____ Address _____ City _____ State _____ Zip _____21. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____22. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____23. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____24. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____25. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____26. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____27. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____28. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____29. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____30. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____31. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____32. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____33. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____34. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____35. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____36. ADDRESS:
Name _____ Address _____ City _____ State _____ Zip _____RECEIVED
FEDERAL BUREAU OF INVESTIGATION
NOV 20 1947
BUREAU

THIS FORM IS FOR THE USE OF THE FEDERAL BUREAU OF INVESTIGATION, U.S. DEPARTMENT OF JUSTICE, AND IS NOT TO BE USED BY OTHER GOVERNMENT AGENCIES.

DO NOT USE THIS FORM FOR POLICE PURPOSES.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

10398

Reg. Dist. No.

304

1. PLACE OF DEATH:

County..... Washington

City or town..... Rural Hancock, Md.

(If outside city or town limits, write RURAL and give nearest town)

7 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hancock, Md. R.D. 1

How long in hospital or institution?

3. (a) FULL NAME

Nancy Ellen Fisher

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Calendine Fisher

B.(c) If alive, give age: years

7. Birth date of deceased (mo. day, yr.)

April 4, 1864

8. AGE: Years: 83 Months: 7 Days: 0 It less than one day: hrs: min:

9. Birthplace: Fulton County, Pa. (Town, county, and state)

10. Usual occupation: Home Duties

11. Industry or business

12. Name: Joseph Barnhart

13. Birthplace: Fulton County, Pa.

14. Maiden name: Mary -----

15. Birthplace: Fulton County, Pa.

16. Informant: Archie Fisher

Address: Hancock, Md. R D 1

17. Burial

(Burial, cremation, or removal. Which?) Date thereof: Nov. 6, 1947

(month) (day) (year)

Cemetery or crematory: Cedar Grove Cemetery

Location: Near Dott, Pa.

18. Funeral director: Snyder-Rowland Funeral Home

Address: Hancock, Md.

19. 11/5/47 (Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State: Maryland

County: Washington

City or town: Rural Hancock, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Hancock, Md. R.D. 1

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

November 4, 1947 12:30 A.M.

2D. DATE OF DEATH:

Nov 4 1947 to Nov 4 1947

and that I last saw her alive on Nov 4 1947

Immediate cause of death:

Chronic Myocarditis

Due to:

Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE:

M. D. or other:
Signature: M. Shaffer
Address: Hancock, Md.
Date signed: 11/5/47

RECEIVED

NOV 8 1947

FBI - BUREAU

Dr/ Corad

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

cc Reg. Dist. No. 1038305

1. PLACE OF DEATH:
 County Washington
 City or town Breathedsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 3 Months
 Hospital, institution, or street address where death occurred:
 Md. State Reformatory for Males
 How long in hospital or institution? 3 Mos.

13
 2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Washington
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1108 W. Lexington St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

FREDERICK I. FOSTER

4. Sex Male	5. Color or race Colored	6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife ---
 6.(c) If alive, give age --- years

7. Birth date of deceased (mo. day, yr.) October 20 1924

8. AGE: Years 23 Months 0 Days 20 It less than one day hrs. min.

9. Birthplace Baltimore Md.
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ---

MOTHER FATHER 12. Name No. record

13. Birthplace No Record

MOTHER FATHER 14. Maiden name Chaney Foster

15. Birthplace Baltimore

16. Informant Records of Md. State Ref. for Males

Address Breathedsville Md.

17. Burial Date thereof 11/12/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mount Auburn Cemetery

Location Baltimore, Maryland

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov 10 1947 John H. Beck
 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 10 1947 47 4.30 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 1947 to Nov 10 1947
 and that I last saw him alive on Nov 9, 1947

Immediate cause of death Pulmonary Tuberculosis
 DURATION 1 year

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings or operations:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D.

M. D. or other Hagerstown, Md.

Address Date signed 11-10-47

RECEIVED

NOV 14 1947

ST READING

68
 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50X

10400

306

Reg. Dist. No. 744

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
 County Washington
 City or town Gaithersburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days
 Hospital, institution, or street address where death occurred: Pritchett Hospital
 How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Baltimore City
 City or town Baltimore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1403 Coates St.
 (If rural, give LOCATION)

3. (a) FULL NAME

Agnes George

3. (b) Social Security Number

4. Sex	5. Color of race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife	Rudolph
-------------------------------	---------

7. Birth date of deceased (mo., day, yr.)	Jan. 21, 1906	6.(c) If alive, give age years
---	---------------	--------------------------------

8. AGE:	Years 41	Months 9	Days 21	If less than one day hrs. min.
---------	----------	----------	---------	--

9. Birthplace	Baltimore, Md.
---------------	----------------

(Town, county, and state)

10. Usual occupation.

11. Industry or business

12. Name	August Grawauski
----------	------------------

13. Birthplace	Poland
----------------	--------

14. Maiden name	Mary Fright
-----------------	-------------

15. Birthplace	Poland
----------------	--------

16. Informant	Pritchett Hospital
---------------	--------------------

Address	Cascade, Md.
---------	--------------

17. (Burial, cremation, or removal, Which?)	Date thereof Nov. 15, 1947
---	----------------------------

(month) (day) (year)	
----------------------	--

Cemetery or crematory	Holy Cross
-----------------------	------------

Location	Anne Arundel Co., Md.
----------	-----------------------

18. Funeral director	M. L. Crampton & Son & Ch.
----------------------	----------------------------

Address	Thurmont, Md.
---------	---------------

19. (Date rec'd by registrar)	Nov. 12, 1947
-------------------------------	---------------

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 12, 1947, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 1947, to November 12, 1947, and that I last saw her alive on November 12, 1947.

Immediate cause of death Carcinomatosis

Due to Carcinoma of Breast

1 year?

DURATION 5 months

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations Carcinoma of Breast

John Hopkins Hosp. Date of op. Dec. 17, 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Fall Injured at work

E. Fort Ave. Md.

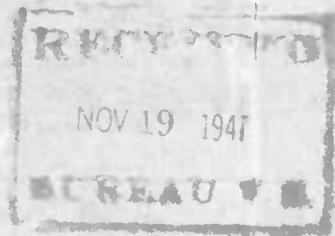
23. SIGNATURE Thomas M. Armitage, M.D.

M. D. or other

Address Pritchett Hospital Date signed Nov. 12, 1947

Cascade, Md.

Nov. 4, 1947 Geo. W. Ferguson



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10401

950

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

60 years.

Hospital, institution, or street address where death occurred

Boonsboro Md. Route 2

How long in hospital or institution?

at Home

3. (a) FULL NAME

Dottie May Green

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

Single

7. Birth date of deceased (mo., day, yr.)

September - 4 1880

8. AGE:

Years
67Months
2Days
1

If less than one day

hrs. min.

B. Birthplace near Boonsboro Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

House Keeper

11. Industry or business

Own Home

MOTHER FATHER

12. Name Daniel P. Green

13. Birthplace near Boonsboro Wash. Co. Md.

Mary A. Marker

14. Maiden name

15. Birthplace near Myersville Fred. Co. Md

Carroll Co. Md

16. Informant

Carrie Green

Address

Boonsboro Md. R. 2

17. Burial

Date thereof Nov. 8-1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Boonsboro Cemetery

Location

Boonsboro Md.

18. Funeral director

Wm J. Best & Sons

Address

Boonsboro Md.

19. Nov. 8 - 1947

John H. Best

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

Washington

City or town..... Appleton - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No..... Boonsboro Md. R. 2

(If rural, give LOCATION)

2.(a) If veteran, name war..... No.

3. (b) Social Security Number

None.

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 5 1947 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

August 7 1947 to Nov. 5 1947

and that I last saw her alive on Nov. 5 1947

Immediate cause of death

Cerebral Hemorrhage

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

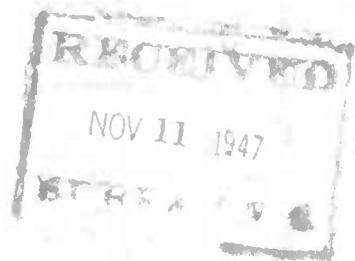
John Best Jr. M.D.

M. D. or other

Boonsboro, Md.

Date signed 11/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 10402 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 years

Hospital, institution, or street address where death occurred:

Garlock Conv. Home

How long in hospital or institution? 9 months

3. (a) FULL NAME

Jessie C. Harris

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Walter Harris

7. Birth date of deceased (mo. day. yr.) June 7, 1861

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
86 5 17 hrs. min.9. Birthplace River Fall, Wisconsin
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name George Mappes

13. Birthplace Not Known

14. Maiden name Ellen Gates

15. Birthplace Not Known

16. Informant Mrs. E. D. Plummer

Address Hagerstown, Maryland

17. Burial Date thereof 11-27-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Waverly Cemetery

Location Waverly, Virginia

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Nov. 25 1947 *Beth Powers*
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 1310 Oak Hill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 Nov 1947 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1935 to 24 Nov 1947

and that I last saw her alive on 23 Nov 1947

Immediate cause of death

Arterio sclerotic Cardio Vasculer
disease

DURATION

15-20 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

7 My

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE *J. J. Husby*

M. D. or other

Address *2301 Belmont* Date signed *25 Nov 47*

RECEIVED

NOV 28 1947

LIBRARY

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Ditto

480X
10403
302

Reg. Dlat. No.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1823 Virginia Ave.

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1823 Virginia Ave.

(If rural, give LOCATION)

None

2.(a) If veteran, name war.

3. (a) FULL NAME

MRS NELL BOWMAN HARTZELL

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married

6.(b) Name of husband or wife Rev. Walter Hartzell

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo. day. yr.) October 26, 1894 1894

8. AGE: Years Months Days If less than one day
53 0 15 hrs. min.9. Birthplace Harrisonburg, Rockingham Co., Va.
(Town, county, and state)

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11 1947 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1 1946 to Nov 11 - 1947
and that I last saw her alive on Nov 10 - 47 1947

Immediate cause of death

Cerebrovascular

DURATION

2 yrs

10. Usual occupation Matron

11. Industry or business Homewood Church Home

12. Name John R. Bowman

13. Birthplace Harrisonburg Va.

14. Maiden name Ocieola Michael

15. Birthplace Harrisonburg Va.

16. Informant Rev. Walter R. Hartzell

Address Hagerstown Md.

17. Burial Date thereof 11/15/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Andrews Union Cemetery

Location Perkasie Pa.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 14. 1947 (Date rec'd by registrar)

Registrar

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

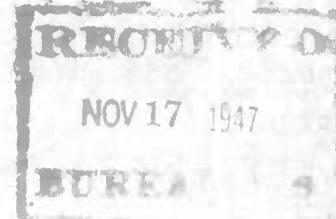
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. W. L. Ditto M. D. or other

Address Hagerstown Md. Date signed 11/15/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10404

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County Hagerstown

City or town. Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1 week Washington County Hospital
 How long in hospital or institution?

3. (a) FULL NAME Doris Morgan Henderson

4. Sex <u>Male</u>	5. Color or race <u>Negro</u>	6. (a) Single, married, widowed, or divorced
--------------------	-------------------------------	--

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.) July 8, 1947

8. AGE: Years 4 Months 7 Days 0 If less than one day
 . hrs. . min.

9. Birthplace Hagerstown, Washg. Md.
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business Joseph Henderson

MOTHER FATHER
 12. Name Joseph Henderson
 13. Birthplace Williamsport, Md

14. Maiden name Thelma Henderson
 15. Birthplace Burkittsville, Md

16. Informant Mrs. Joseph Henderson
 Address 138 Williams Ave.

17. Burial Burial
 (Burial, cremation, or removal, Which?) Date thereof 11/18/47
 (month) (day) (year)

Cemetery or crematory Riverview Cemetery
 Location Williamsport, Md

18. Funeral director Wm H Dorney
 Address 291 Frederick St.

19. Nov. 18. 1947 Sweet Flowers.
 (Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 138 Williams Ave.
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 15th 1947 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 10th 1947 to Nov. 15th 1947 and that I last saw her alive on Nov. 15th 1947

Immediate cause of death

Whooping Cough

DURATION

3 Wks.

Due to

Due to

Other conditions Bronchopneumonia
Atelectasis 5 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

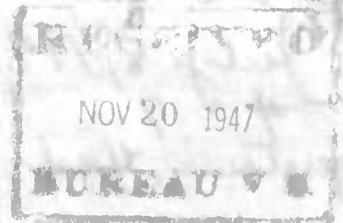
Means of injury

Injured at work?

23. SIGNATURE Julia Morgan

M. D. or other

Address Hagerstown, Md Date signed 4/17/67



NOV 20 1947

BUREAU WASH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1910

10405

Reg. Dist. No.

302

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
428 W. Franklin St.

How long in hospital or institution?

3.(a) FULL NAME

Sarah Annie Henson

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife John Henson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) January 16, 1879

8. AGE: Years 68 Months 9 Days 16 It less than one day hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

12. Name John Henson

13. Birthplace Hagerstown, Md.

14. Maiden name Sarah Ann Slaughter

15. Birthplace Hagerstown, Md.

16. Informant Mrs. Mary A. Maddran

Address Hagerstown, Maryland

17. Burial Date thereof Nov. 4 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

Nov. 4 1947 *Robert P. Conrad, M.D.*
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 428 W. Franklin St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov 1

47

at 2 35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1 1945 to Nov 1 1947

and that I last saw her alive on Nov 1 1947

Immediate cause of death

Ch. Myocarditis

Ch. Tuberculous hepatitis

DURATION

5 yrs

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.
M. D. or other
Address Hagerstown, Md. Date signed Nov 3 1947

RECEIVED

NOV 6 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

10406

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON
City or town HAGERSTOWN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 WEEKS

Hospital, institution, or street address where death occurred:

WASHINGTON COUNTY HOSPITAL
3 WEEKS

How long in hospital or institution?

3. (a) FULL NAME

LIZZIE M. HORST

3. (b) Social Security Number

NONE

4. Sex

5. Color or race WHITE 6.(a) Single, married, widowed, or divorced WIDOWED8.(b) Name of husband or wife MARTIN M. HORST7. Birth date of deceased (mo., day, yr.) JULY 23, 18798. AGE: Years 68 Months 4 Days 1 If less than one day

hrs. _____ min. _____

9. Birthplace LEITERSBURG, WASHINGTON, MD.
(Town, county, and state)10. Usual occupation. HOUSEWIFE

11. Industry or business

12. Name JOHN A. STRITE
13. Birthplace MARYLAND14. Maiden name KATHERINE MAUN
15. Birthplace PENNSYLVANIA16. Informant Mrs. Herman Martin
Address Hanover, Pa.17. Burial Date thereof 11/27/47
(Burial, cremation, or removal. Which?) Burial (month) (day) (year)Cemetery or crematory Reiff Cemetery
Location Washington County, Md.18. Funeral director Golford J. Flanagan
Address Hagerstown, Md.19. Mos. 24. 1947 - Oct. 24.
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County WASHINGTONCity or town CLEARFOSS, HAGERSTOWN RT. #4
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)2.(a) If veteran, name war NON-VET.

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 24 - 47 at 94 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1-47 to Nov 24-47and that I last saw her alive on Nov 24-47 19_____Immediate cause of death. Cardio Vascula DiseaseDue to FrightsDue to Frights

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings or operations. _____ Date of op. _____

Autopsy results. _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE E. A. H. M. D. or other Dr. H.Address Hagerstown, Md. Date signed 1947



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

10407

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

Washington

County

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

66 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Home

How long in hospital or institution?

15 years

3. (a) FULL NAME

Harry Lehman Jones

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

white

widowed

6.(b) Name of husband or wife

Eva Jones

7. Birth date of

deceased (mo., day, yr.)

December 15, 1880

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

66

11

10

hrs.

min.

9. Birthplace Hagerstown, Wash. Co., Md.

(Town, county, and state)

10. Usual occupation

—

11. Industry or business

Samuel Jones

MOTHER FATHER

Hagerstown, Md.

12. Name

Raechel Smith

13. Birthplace

Hagerstown, Md.

14. Maiden name

Raechel Smith

15. Birthplace

Hagerstown, Md.

16. Informant

Mrs. Wm. E. Seaman

Address

McKeesport, Penna.

17. burial

(Burial, cremation, or removal. Which?)

Date thereof 11-28-47

(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown, Md.

18. Funeral director

Scott F. Minnich & Son

Address

Hagerstown, Md.

Nov. 27, 1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Washington

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov. 25, 1947, at 3:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 12th 1947 to Nov. 25th 1947and that I last saw h. b. alive on Nov. 19th 1947

Immediate cause of death

Arteria sclerosis

Due to Thrombo-phlebitis right leg

Due to Gangrene right heel

Other conditions

DURATION

2 yrs.

4 mos.

3 weeks

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

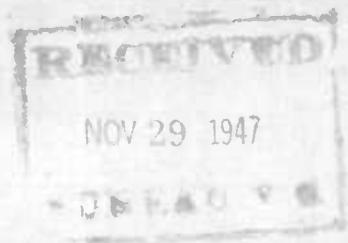
Injured at work?

23. SIGNATURE

Ernest J. Forde MD

M. D. or other

Address Hagerstown, Md. Date signed 11/26/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10408
Reg. Dist. No. 2020

1. PLACE OF DEATH:

Washington

County

Hagerstown

City or town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 2 days

3. (a) FULL NAME

Jo Richard Jones

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 9, 1943

8. AGE:	Years	Months	Days	If less than one day
	4	7	17	hrs. min.

9. Birthplace Hagerstown, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name	George W. Jones
13. Birthplace	Hagerstown, Maryland

14. Maiden name	Francis Elizabeth Davis
15. Birthplace	Highfield, Maryland

16. Informant Mr. George W. Jones
Address 434 George St. Hagerstown, Md17. Burial Date thereof Nov. 29, 1944
(Burial, cremation, or removal. Which?) (month) (day) (year)
Rose Hill CemeteryCemetery or crematory
Location Hagerstown, Maryland18. Funeral director Fred W. Kraiss
Address Hagerstown, Maryland19. Date rec'd by registrar Dec. 1, 1947
Signature Chas. Bowers
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)Street No. 434 George Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number None

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Nov 1947 at 100 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

24 Nov 1947 to 26 Nov 1947

and that I last saw him alive on 25 Nov 1947

Immediate cause of death

Tetanus DURATION 36 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Eldon D. Woodburn M.D. or other

Address 115 W Washington St Date signed 11/28/47

DEC 3 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10409

88a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington, D. C.

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 yrs.

Hospital, institution, or street address where death occurred:

250 Frederick St.

How long in hospital or institution?.....

3. (a) FULL NAME

Susan Jones

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Edward F. Jones

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

1880

8. AGE:

Years
67

Months

Days

If less than one day

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

12. Name..... Thomas Clipp

13. Birthplace..... Maryland

14. Maiden name..... Elizabeth Hoffmaster

15. Birthplace..... Maryland

16. Informant..... Lloyd W. Jones

Address..... Knoxville, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof.....

(month) (day) (year)

Cemetery or crematory..... Brethren

Location..... Brownsville, Md.

18. Funeral director..... C. H. Feete & Pro.

Address..... Brunswick Md.

Nov. 7. 1947 Ghost Bowers

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Wash

City or town..... Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 250 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov. 7 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death

Acute cerebral hemorrhage

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

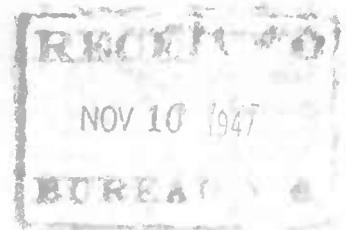
23. SIGNATURE

J. Robert Wells DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. certifies

Address..... Hagerstown, Md. Date signed 11/7/47



Birth and Death. 10410
159 Reg. Dist. No. 302

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF STILLBIRTH

A certificate must be filed within 24 hours for every still birth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:

County Washington
 City or town Hagerstown, md.
(If outside city or town limits, write RURAL and give nearest town)
 Street address, hospital, or institution:
Washington County Hospital
 Length of mother's stay in County
(How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:

State Maryland
 County Washington
 City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 844 Marshall St
(If RURAL give LOCATION)

3. Name of child Baby Girl Kay

4. Date of birth Nov. 10 1947 Hour 2 53 P.M.

5. Sex female 6. Twin or triple

7. No. of weeks pregnancy 5

FATHER OF CHILD

8. Full name Charles Brundell Kay

9. Color W 10. Age at time of this birth 26 yrs.

11. Usual occupation Shoe worker

MOTHER OF CHILD

12. Full maiden name Lillian Dorothy Binkle

13. Color W 14. Age at time of this birth 24 yrs.

15. Usual occupation House wife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living? 0
 (b) How many other children were born alive but are now dead? (c) How many other children were born dead? 0

17. Did child die before labor? No During labor? No

18. Pregnancy, complications of

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.

19. Labor: (a) Complications of

(a) Fetal causes

(b) Induced?

(b) Maternal causes unknown

20. (a) Was there an operation for delivery? No

(Yes or No)

(b) State all operations, if any

22. I certify to the birth of this child who was born dead on the date and hour above stated.

Signature Elletta Farmer, M.D.

(Specify if M. D., midwife, or other)

Address Hagerstown, Md.

(c) Did child die before operation?

During operation?

23. (a) Burial (b) Date thereof 11/11/47
(Burial, cremation or removal) (month) (day) (year)

(c) Cemetery or crematory ROSE HILL Cemetery

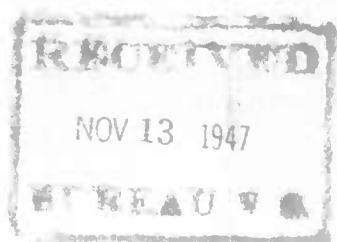
24. (a) Funeral director P. Andrew W. K. Goffman

(b) Address Hagerstown, Md.

25. (a) Nov. 11, 1947 (b) Death
(Date rec'd by registrar) (Registrar)

26. (To be filled out if no physician was present at delivery.)
 The above certificate has been examined by me.

Health Officer, per.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10411

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

WASHINGTON
HAGERSTOWN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs

Hospital, institution, or street address where death occurred:

WASHINGTON COUNTY HOSPITAL

How long in hospital or institution? 42 DAYS

3. (a) FULL NAME

MAZIE BRYAN KENDALL

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

Roy L. KENDALL

7. Birth date of deceased (mo., day, yr.)

MAY, 8, 1898

6. (c) If alive, give age 48 years

8. AGE:

Years 49 Months 6 Days 3 If less than one day hrs. min.

9. Birthplace

INWOOD, BERKLEY, W. VA.

(Town, county, and state)

10. Usual occupation.

HOUSEWIFE

11. Industry or business

CHARLES L. BUTLER

MOTHER FATHER DARKSVILLE W. VA.

14. Maiden name ANNA MARY KISNER

15. Birthplace HANCOCK, MD.

16. Informant Roy L. Kendall

Address

137 John St.

17. Burial

Date thereof 11/13/47

(month) (day) (year)

Cemetery or crematory

Rose Hill

Location Hagerstown, Md.

18. Funeral director Woodford J. Norment

Address Hagerstown, Md.

Nov. 12, 1947

Death record by registrar

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

MARYLAND

County WASHINGTON

City or town HAGERSTOWN

(If outside city or town limits, write RURAL and give nearest town)

Street No. 137 JOHN STREET

(If rural, give LOCATION)

2. (a) If veteran, name war Non-VET

MEDICAL CERTIFICATION

20. DATE OF DEATH November 11, 1947, at 17¹⁰ A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2, 1947, to November 11, 1947.

and that I last saw her alive on November 10, 1947.

Immediate cause of death.

Carcinoma of uterus. DURATION 16 mos.

Due to.

Due to.

Caesaria of pregnancy Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

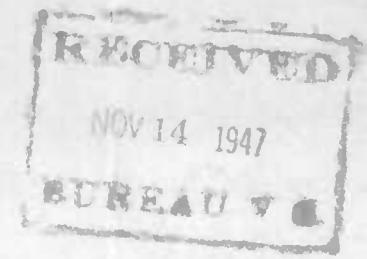
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE RB Norment M.D.

Address Hagerstown, Md. M. D. or other

Date signed 11/13/47



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

10412

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.

Hospital, institution, or street address where death occurred:

315 West Side Ave.

How long in hospital or Institution? at home

3. (a) FULL NAME

Jennings - M - Kline

4. Sex

Male White Married

6. (b) Name of husband or wife Frances Metz Kline

7. Birth date of deceased (mo., day, yr.) November 2 - 1908

8. AGE: Years	Months	Days	It less than one day
39	0	8	hrs. min.

9. Birthplace Westport Md.

10. Usual occupation Sheet metal Worker

11. Industry or business Pangborn Corp.

12. Name	John W. Kline
----------	---------------

13. Birthplace	Virginia
----------------	----------

14. Maiden name	Sarah Kline
-----------------	-------------

15. Birthplace	Virginia
----------------	----------

16. Informant	Mrs. Frances Metz Kline
---------------	-------------------------

Address	315 West Side Ave. Hagerstown
---------	-------------------------------

17. Burial	Date thereof Nov. 12, 1947
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory	Mano Cemetery
-----------------------	---------------

Location near	Hagerstown Md.
---------------	----------------

18. Funeral director	W.M.J. Boat & Sons
----------------------	--------------------

Address	Boonsboro Md.
---------	---------------

19. Nov. 11, 1947	19. (Date rec'd by registrar)	Registrar
-------------------	-------------------------------	-----------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 West Side Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World War 2 -

3. (b) Social Security Number

175-10-9735

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov / 10 / 47 19 12:50A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19.

and that I last saw him alive on

Immediate cause of death

coronary occlusion

Due to

acute coronary occlusion

(2nd occlusion)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

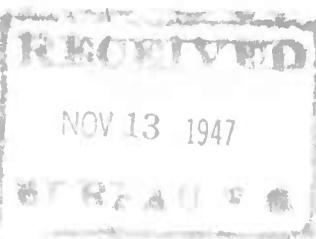
Injured at work?

23. SIGNATURE S. Robert Wells

WASH. CO., MD.

M. D. or

Address Nov. 11, 1947 Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1860

PC

11/11/56

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Washington
County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... since Sept 23, 1947

Hospital, institution, or street address where death occurred:

Ritchie Hospital
since Sept 23, 1947

How long in hospital or institution?.....

3. (a) FULL NAME

Pufus Lavender

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Divorced

6. (b) Name of husband or wife..... Dorothy M. Lavender

7. Birth date of deceased (mo., day, yr.)..... April 9, 1907

6. (c) If alive, give age..... years

8. AGE: Years 40 Months 6 Days 23 It less than one day hrs. min.

9. Birthplace..... Virginia

(Town, county, and state)

10. Usual occupation..... Bank Teller.

11. Industry or business

12. Name..... Samuel A. Lavender.

13. Birthplace..... Virginia

14. Maiden name..... Mamie A. Bowles.

15. Birthplace..... Virginia

16. Informant..... Mrs. Hazel O'Malley.

Address..... 3020 Fisby St.

17. Burial..... Date thereof..... Nov 5 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oakwood

Location..... Richmond, Va.

18. Funeral director..... Chenevert & Sonoran

Address..... 3615-17 Chestnut Ave.

19. (Date rec'd by registrar) 19..... Registrars Initials..... X.W. Hadrick

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 3020 Fisby St.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Nov. 2 1947 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 23 1947 to Nov. 2 1947

and that I last saw him alive on Nov. 2 1947

Immediate cause of death.....

Acute pyelonephritis
with septicemia

DURATION

1 mo.

3 days

Due to.....

Due to.....

Other conditions..... Paraplegia, due to
compression fracture 10th thoracic
(include pregnancy within 3 months of death) vertebra

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of Feb. 1947

Where did injury occur?..... 1700 N. Chas. St., Beltsville, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... Martin J. Barry Co.

Means of injury..... Fell down open elevator shaft. Injured at work? no

23. SIGNATURE..... Thomas M. Arrington, M.D.
M. D. or other

Address..... Ritchie Hospital Date signed Nov 2, 1947

Cascade, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

77d

10414

Reg. Dist. No.

302

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Washington
County.....

Hagerstown, Md.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

419 West Franklin St.

How long in hospital or institution?

3. (a) FULL NAME

Anna Battle Lee

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Philip L. Lee

7. Birth date of deceased (mo., day, yr.)

Unknown

6.(c) If alive, give age..... years

8. AGE: Years

About 60

Months

Days

It less than one day

.... hrs. min.

9. Birthplace

Hagerstown, Wash. Co., Md.

(Town, county, and state)

10. Usual occupation

Home Duties

11. Industry or business

Michael Battle

MOTHER FATHER

12. Name

Unk.

Mary Larkin

13. Birthplace

Unk.

14. Maiden name

Unk.

15. Birthplace

Unk.

Philip L. Lee

16. Informant

Jamacia British W. Indies

Address

Burial

Date thereof Nov. 21, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Maryland

Fred W. Kraiss

18. Funeral director

Address

Hagerstown, Maryland

Burial

Nov. 20, 1947

Death record

Registrar

Address

Signature

Date signed

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Washington

City or town.....

Hagerstown

County.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

419 West Franklin St.

County.....

Washington

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 9/47 about 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death.....

acute alcoholic narcosis

Due to..... chr. alcoholism

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... as above 11/27

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... no Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

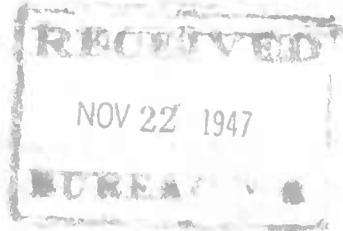
Means of injury..... Injured at work?.....

Signature S. Robert Wells DEPUTY MEDICAL EXAM.

Address Hagerstown, Md. WASH. CO. MD.

M. D. or.....

Date signed Nov. 20 '47



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10415

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 weeks

3. (a) FULL NAME

Caro A. Lyon

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Charles L. Lyon

7. Birth date of deceased (mo. day. yr.) March 1, 1865

8. AGE: Years Months Days If less than one day
82 8 5 hrs. min.9. Birthplace New Haven, Conn.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Heman B. Allen

13. Birthplace New Haven, Conn.

14. Maiden name Margaret E. Ferguson

15. Birthplace Attleboro, Mass.

16. Informant Charles D. Lyon

Address Hagerstown, Maryland

17. Removal Date thereof 11-7-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Walnut Grove Cemetery

Location Meriden, Conn.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. No. 6 1947 Bluff Howard
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 South Prospect Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 6 1947 at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1947 to Nov 6 1947
and that I last saw her alive on Nov 6 1947Immediate cause of death Cardiac - vascular -
rheumatic disease.

(71)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. Campbell
Hagerstown, Md. 11/6/47
M. D. or other

Address

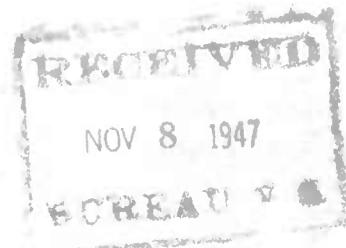
ЛНН ЧО ТИЭМТЯАЗЫН ЭТАТГА СИЛУЯДЫ

Journal of Health Politics, Policy and Law, Vol. 33, No. 3, June 2008
DOI 10.1215/03616878-33-3 © 2008 by The University of Chicago

CERTIFICATE OF EXCELLENCE

202 JAVAN 2

HTA09 40-32419



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10416

Reg. Dist. No.

300

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Washington

County.....

City or town.....Rural--Sharpsburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary M. Marshall

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife.....

Edward Marshall--Deceased

7. Birth date of deceased (mo., day, yr.)

April 25, 1882

8. (c) If alive, give age.....years

8. AGE:

Years
65Months
6Days
21It less than one day
.....hrs.min.

9. Birthplace.....Keedysville-Washington-Maryland

(Town, county, and state)

10. Usual occupation.....

Home Duties

11. Industry or business

12. Name.....Frederick Holmes

13. Birthplace.....Keedysville, Md

14. Maiden name.....Unknown

15. Birthplace

16. Informant.....Leon Ebersole

Address.....Rural--Sharpsburg, Md

17. Burial.....Date thereof...Nov. 18, 1947
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....Mt. View

Location.....Sharpsburg, Md

18. Funeral director.....R. I. Earnshaw

Address.....Keedysville, Md

19. "11/18/47
(Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland.....County.....Washington

City or town.....Rural--Sharpsburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH

NOV. 16 1947, at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan 18, 1947, to Nov 18, 1947;
and that I last saw her alive on Nov 18, 1947.

Immediate cause of death.....

Respiratory

DURATION

1 month

Due to.....Chronic arteriovascular nephritis
and malignant hypertension
2 years.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....(City or town).....(County).....(State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....Sharpsburg, Md.....Date signed.....11/17/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10417

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington
 County: Hagerstown
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 25 years
 Hospital, institution or street address where death occurred:
Washington County Hospital
 How long in hospital or institution? Seven days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Maryland County: Washington
 City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)
 Street No.: 314 W. Jonathan Street
 (If rural, give LOCATION)

3. (a) FULL NAME Polly Jane Mc Intosh

4. Sex Female 5. Color or race Negro (e) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Lucius Mc Intosh

7. Birth date of deceased (mo. day. yr.) 1910 6. (c) If alive, give age years

8. AGE: Years 37 Months Days If less than one day hrs. min.

9. Birthplace Rockingham, Richmond, N. C. (Town, County, and state)

10. Usual occupation Domestic

11. Industry or business

12. Name Charles Leak 13. Birthplace Rockingham, N. C.

14. Maiden name Maggie Adams 15. Birthplace South Carolina

16. Informant Mrs. Lillian Ellerbee

Address 1000 E. Washington St., Rockingham N.C.

17. Burial Date thereof 11/7/47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery Location Hagerstown, Md.

18. Funeral director Williams & Dawson

Address 291 Frederick St Hagerstown

19. Nov. 7, 1947 Bethelwees (Date rec'd by registrar)

Registrar

3. (b) Social Security Number Zone

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 4th 1947 at 11:05 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 30 1947 to Nov. 4th 1947and that I last saw her alive on Nov. 4th 1947Immediate cause of death Occlusion of the coronary arteries DURATION 5 wks.Due to Syphilitic aortitis ?Due to Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results as above Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

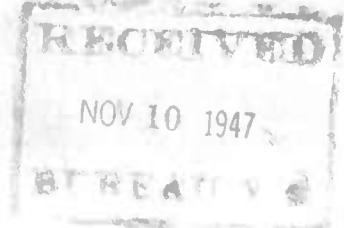
22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, pub' place (where?)

Means of injury Injured at work? 23. SIGNATURE Lucy Johnson M.D. M. D. or other Address 159 W. Washington St Date signed 11/13/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

10418

302

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

Washington County

Hagerstown City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days

Hospital, institution, or street address where death occurred: Washington County Hospital

How long in hospital or institution? 21 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland State

Washington County

Hagerstown City or town

(If outside city or town limits, write RURAL and give nearest town)

714 West Franklin St. Street No.

(If rural, give LOCATION)

None 2.(a) If veteran, name war.

3. (a) FULL NAME

MRS ELIZABETH MOATS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6.(b) Name of husband or wife Hiram O.

7. Birth date of deceased (mo. day. yr.) May 7 1867

8. AGE: Years Months Days If less than one day

80 6 10 hrs. min.

9. Birthplace Fairplay Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

12. Name Samuel Kitzmiller

13. Birthplace Fairplay Md.

14. Maiden name Rachael Richard

15. Birthplace Martinsburg W. Va.

16. Informant Mrs. Max Weaver

Address Hagerstown Md.

17. Burial Date thereof 11/19/47
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Manor Cemetery

Location near Tilghmanton Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 17 1947 Death House

(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 17 1947

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

Sept 6 1947 to Nov. 17 1947
and that I last saw her alive on November 16 1947

Immediate cause of death

Hypertension Cardiac -
vascular disease

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

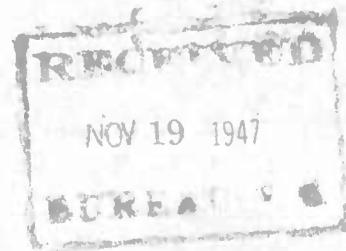
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Sidney Novenstein M.D.

M. D. or other

Address Hagerstown Md. Date signed 11-17-47



1
PLEASE WRITE PLAINLY, WITH UNFADING INK.
Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10420

61

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

1030 Main Avenue

How long in hospital or institution?

3. (a) FULL NAME

Nanny Florence Montgomery

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

John F. Montgomery

7. Birth date of deceased (mo., day, yr.)

November 29, 1876

6.(c) If alive, give age years

8. AGE:

Years 71

Months 0

Days 5

It less than one day

hrs. min.

9. Birthplace

Washington County Maryland

(Town, county, and state)

10. Usual occupation

Home Duties

11. Industry or business

MOTHER FATHER

William Wade

13. Birthplace

Washington Co. Md.

14. Maiden name

Roseanna

15. Birthplace

Unknown

16. Informant

Dr. Daniel Montgomery

Address 1030 Main Ave. Hagerstown, Md.

17. Burial

Date thereof Nov. 16, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory

Smithburg Cemetery

Location

Smithburg, Maryland

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Maryland

Nov. 16 1947
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1030 Main Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov 12 1947

and that I last saw her alive on Nov 12 1947

Immediate cause of death

Bronchial pneumonia

DURATION

11-12 hrs

Due to

Due to

Aureum Glutathione 640 +
Hyperthyroidism - Cerebral vascular 640 +

Diabetes mellitus 540 +

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

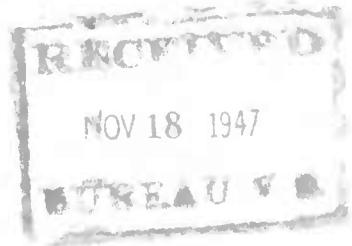
Injured at work?

23. SIGNATURE

J.W. Layman, M.D. or other

Address August 2nd 1947 Date signed

5741 ADAMSON
C. S. W.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

57

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10418303
Reg. Diat. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

3 weeks

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

3 weeks

3. (a) FULL NAME

Elizabeth Bowers Moore

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female White

Widow

6.(b) Name of husband or wife

George H. Moore

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

March 30, 1876

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Big Spring- Wash. co. Md.

(Town, county, and state)

10. Usual occupation.

Home Duties

11. Industry or business

MOTHER FATHER

12. Name James Bowers

13. Birthplace

Unknown

14. Maiden name

Susan Shetz

15. Birthplace

Unknown

16. Informant

Miss Hilda Moore

Address

Big Pool, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Nov. 27 1947
(month) (day) (year)

Cemetery or crematory

Shanktown Cemetery

Location

Shanktown, Md.

18. Funeral director

Snyder-Rowland Funeral Home

Address

Hancock, Md.

Nov. 27 1947
(Date rec'd by registrar)Joseph W. Murray
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Big Pool

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Nov. 25, 1947 19 6:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1, 1947, to Nov. 25, 1947

and that I last saw her alive on Nov. 24

19 47

Immediate cause of death

Cerebral Sclerosis

1 mo.

Due to

Arterio Sclerosis

5 yrs

Due to

Diabetes Insipidus

6 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

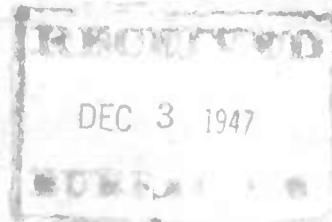
Means of injury

Injured at work?

23. SIGNATURE David P. Brewer M.D.

M. D. or other

Address Clear Spring Md Date signed 11/23/47



50
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

CERTIFICATE OF DEATH

1043103
Reg. Dist. No.

1. PLACE OF DEATH:

Washington County

Charlton City or town

(If outside city or town limits, write RURAL and give nearest town)

Life

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3.(a) FULL NAME

Fannie Laura Myers

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Calvin M. Myers

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1885

8. AGE: Years Months Days It less than one day
62 2 8 hrs. min.9. Birthplace Clearspings, Wash. Co. Md.
(Town, county, and state)

10. Usual occupation Home duties

11. Industry or business

John D. Miles
12. NameVirginia
13. BirthplaceAmanda Bowers
14. Maiden nameVirginia
15. BirthplaceMr. Calvin M. Myers
16. InformantCharlton, Maryland
AddressBurial
17. Date thereof Nov. 22, 1947
(Burial, cremation, or removal. Which?)St. Pauls Cemetery
Cemetery or crematoryWestern Pike, Md.
LocationSnyder-Rowland Funeral Home
18. Funeral directorClearsprings, Maryland
AddressNov. 22, 1947
(Date rec'd by registrar)Josephine Myers
Signature

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland County

Washington City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 19 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 1940 to Nov. 19 1947

and that I last saw her alive on Nov. 19, 1947

Immediate cause of death

Cerebral Hemorrhage
Duration 3 daysDue to Arterio Sclerosis
Duration 10 yrs.

Due to

Tic Douloureux
Ruptured Vertebral Disc
Duration 10 yrs.

Include pregnancy within 3 months of death

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

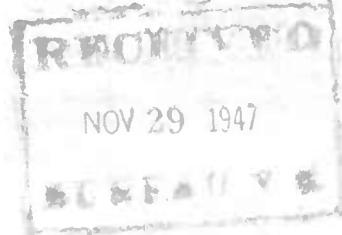
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE David P. Brewer M.D.

M. D. or other

Address Clear Spring Md. Date signed 11/22/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

49

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10422

CERTIFICATE OF DEATH

Reg. Dist. No.

303

93d

1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

5 months

Hospital, institution, or street address where death occurred:

Big foot

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

B. (b) Name of husband or wife

Mary E. Nichols

7. Birth date of

deceased (mo., day, yr.)

May 3, 1874

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73

6

15

hrs.

min.

9. Birthplace

Cascade, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Augustus Nichols

12. Name

Cascade, Md.

13. Birthplace

Susan Royer

14. Maiden name

Cascade, Md.

15. Birthplace

Tina Clarence Ferguson

16. Informant

Burial

Date thereof Nov 20 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Bethel Cemetery

Location

Blue Ridge Mountain

18. Funeral director

Walter F. Rose

Address

Haymarket, Va.

Nov 19

1947

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Big foot

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 17, 1947 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from APRIL 12 1947 to NOV. 17 1947

and that I last saw him alive on SEPT. 6 1947

Immediate cause of death

CORONARY OCCLUSION
SCUTE

DURATION

1 hr.

Due to

Myocarditis chronic

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

NONE

Date of op.

Autopsy results

NONE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Audie B. Lee Cohen M. D. C. M.

Address Clear Spring, Md. Date signed Nov. 18/47

RECEIVED BY TENGSHAW STATE GUARDIAN
RECORDED BY STACI HUTCHINSON

RECORDED BY

NOV 21 1947

RECORDED BY

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

10423

Reg. Dist. No.

302

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

217 Norway Avenue

How long in hospital or institution?

3. (a) FULL NAME

John Huss Patterson

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 6, 1867

8. AGE:

Years
90Months
4Days
19If less than one day
..... hrs. min.

9. Birthplace

Franklin County Penna.

(Town, county, and state)

10. Usual occupation.

11. Industry or business

MOTHER FATHER

Joseph Patterson

Penna.

Elizabeth Weitich

Germany

16. Informant

Mrs. Alvey Strock

Address 217 Norway Ave. Hagerstown, Md.

17. Burial

Date thereof Nov. 28, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Thomas Cemetery

Location

St. Thomas, Penna.

18. Funeral director

Barbour Funeral Home

Address

Chambersburg, Penna.

Nov. 26, 47 - Ghost Boarded

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 217 Norway Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

November 24, 47, 19 al 9: 15P.M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... 45, to November 24, 19... 47.

and that I last saw h. im. alive on November 24, 19... 47.

Immediate cause of death Chronic Nephritis

DURATION

2 yrs.

Due to

Due to

Other conditions General Arteriosclerosis

ind.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

7. Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

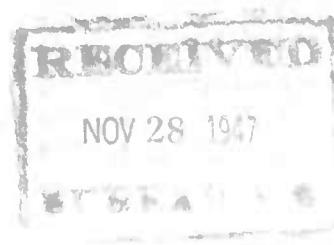
Injured at work?

23. SIGNATURE

B. Blasberg, M.D.

M. D. or other

Address 148 W. Washington St.. Date signed Nov, 26



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10424

CERTIFICATE OF DEATH

122a
Reg. Dist. No.

302

1. PLACE OF DEATH:

Washington

County

Hagerstown

City or town

(If outside city or town limits, write RURAL and give nearest town)

5 weeks

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

5 weeks

3. (a) FULL NAME

Charles Lewis Perkins

3. (b) Social Security Number

None

4. Sex Male	5. Color or race White	6. (a) Single, married, widowed, or divorced Married
----------------	---------------------------	---

6. (b) Name of husband or wife
Mrs. Viola Perkins

6. (c) If alive, give age 74 years

7. Birth date of deceased (mo. day, yr.) Dec. 17, 1872

8. AGE: Years 74	Months 10	Days 27	If less than one day hrs. min.
---------------------	--------------	------------	-----------------------------------

9. Birthplace Lynchburg--Virginia
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Lewis Perkins

13. Birthplace Lynchburg--Virginia

14. Maiden name Mildred May

15. Birthplace Lynchburg--Virginia

16. Informant Mrs. Viola Perkins

Address Keedysville, Md

17. Burial Date thereof May 16, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Funkstown

Location Funkstown, Md.

18. Funeral director R. I. Earnshaw

Address Keedysville, Md

19. Nov. 14, 1947
(Date rec'd by registrar) *Chartt Powers*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Keedysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct. 13, 1947 at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 9, 1947, to October 13, 1947,

and that I last saw him alive on October 12, 1947.

Immediate cause of death

Chronic Myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations Two ruptured coronary arteries
Date of op. Oct. 9, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

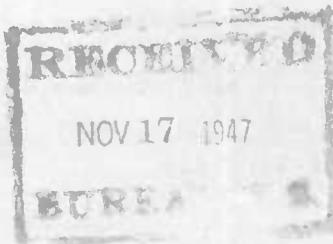
Means of Injury

Injured at work?

23. SIGNATURE *J. W. E. M.D.*Address *Boonsboro*

M. D. or other

Date signed *Nov. 18, 1947*



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10425

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown Maryland

(If outside city or town limits, write RURAL and give nearest town)

5 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Home

How long in hospital or institution?

3. (a) FULL NAME

George W. Phillips

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widower

6. (b) Name of husband or wife Blanche S. Phillips

7. Birth date of deceased (mo. day yr.) April 15, 1865

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
82 7 2 hrs. min.

9. Birthplace Luray, Virginia

(Town, county, and state)

10. Usual occupation Retired Laborer

11. Industry or business

12. Name Not Known

13. Birthplace Not Known

14. Maiden name Not Known

15. Birthplace Not Known

16. Informant Robert Lichliter

Address Luray, Va.

17. Burial Date thereof 11-19-47
(Burial, cremation, or removal; Whish?) (month) (day) (year)

Cemetery or crematory Green Hill Cemetery

Location Luray, Va.

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. (May be filled by registrar)

Date reg'd by registrar Clear H. Brooks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. Hagerstown Route #4

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 17 1947 at 2nd P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 1 st 1947 to Nov. 17 1947

and that I last saw him alive on Nov. 17 1947

Immediate cause of death

Coronary Occlusion

Due to:

Hypertension

Due to: Of tricuspiditis

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Ernest A. Goldsmith

M. D. or other

Address Hagerstown Md. Date signed 11/17/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10420

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH:

County Washington County

City or town Williamsport, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 month

Hospital, Institution, or street address where death occurred:

21 N. Vermont St., Williamsport, Md.

How long in hospital or institution?

3. (a) FULL NAME

Charles Blucker Potts

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

Male White Married

6.(b) Name of husband or wife Florence Hoffman Potts

7. Birth date of deceased (mo., day, yr.) Nov. 3 1907 6.(c) If alive, give age 36 years

8. AGE: Years Months Days It less than one day
39 29 29 hrs. min.9. Birthplace Williamsport, Md.
(Town, county, and state)10. Usual occupation Ice Cream Factory
Hershey Ice Cream

11. Industry or business Hershey Ice Cream

12. Name George Potts

13. Birthplace Williamsport, Md.

14. Maiden name Elizabeth Harsh

15. Birthplace Williamsport, Md.

16. Informant Florence Hoffman Potts

Address Williamsport, Md. RFD #1

17. Burial Date thereof Nov. 4 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery

Location Near Clearspring Md.

18. Funeral director Edith V. Leaf

Address #7 Church St. Williamsport, Md.

19. 11/4 1947 Mrs. E. Lee McElroy
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Williamsport, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 21 Vermont Street, Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION About

Nov/1/47 1A

20. DATE OF DEATH..... 19..... al..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h..... alive on

Immediate cause of death.....

DURATION

Due to Charring burn to.....

entire body

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations no

Antopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide accident Date of Nov/1/47

Where did injury occur? Williamsport Wash. Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

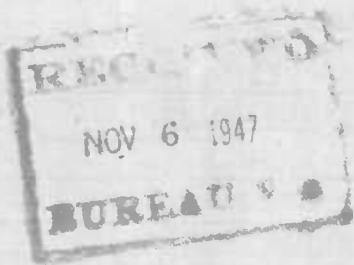
Set bed a fire while

Means of injury smoking cigarette Injured at work? No

23. SIGNATURE

Robert Mulls DEPUTY MEDICAL EXAMINER
WASM CO. MD.
M. D. or other

Address Hagerstown, Md. Date signed 11/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr. Conrad

CERTIFICATE OF DEATH

Reg. Dist. No. 10427
11-15-47

1. PLACE OF DEATH:

County Washington
City or town Breathedsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Months

Hospital, institution, or street address where death occurred:

Md. State Reformatory for Males

How long in hospital or institution? 5 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County --

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 910 St. Barnabas Place

(If rural, give LOCATION)
None

2.(a) If veteran, name war.

3.(a) FULL NAME

JAMES REED

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Single

6.(b) Name of husband or wife --

6.(c) If alive, give age -- years

7. Birth date of deceased (mo. day, yr.) September 6 1925

8. AGE: Years Months Days If less than one day
22 2 8 hrs. min.9. Birthplace Baltimore City Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business --

12. Name Irving Reed

13. Birthplace Baltimore Md.

14. Maiden name Alberta Jones

15. Birthplace Baltimore Md.

16. Informant Records of Md. State Ref. for Mal

Address Breathedsville Md.

17. Burial Date thereof Nov. 17, 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory Md. State Reformatory Cem.

Location Breathedsville Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md

19. Nov. 17. 1947 John H. Baetz
(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947 at 3.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1947 to Nov 14 1947

and that I last saw him alive on Nov 13 1947

Immediate cause of death

Pulm. Tuberculosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.
Hagerstown, Md. Date signed 11-15-47

M. D. or other



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

91

10428
302

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Washington
D.C.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 days.

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?.....

5 days.

3. (a) FULL NAME

William Grimes Rhodes.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Ida Middlekauff Rhodes

7. Birth date of deceased (mo., day, yr.)

August 29 - 1870

6. (c) If alive, give age years

8. AGE:

Years Months Days It less than one day

77 2 12 hrs. min.

9. Birthplace

Downsville Wash. Co. Md.

(Town, county, and state)

10. Usual occupation.....

Farmer

11. Industry or business

Retired

12. Name

Lewis H. Rhodes

13. Birthplace

Emmitsburg Fred. Co. Md.

14. Maiden name

Sarah J. Duthman

15. Birthplace

Waynesboro Penna.

16. Informant

Mrs. Ida M. Rhodes

Address

Fairplay Md. R. I.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof November 14, 1947

(month) (day) (year)

Cemetery or crematory

Bakersville Cemetery

Location

Bakersville Md.

18. Funeral director

W. J. Best & Sons

Address

Boonsboro Md.

19. Date rec'd by registrar

Nov. 13 - 47

S. G. Howard

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Washington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

Fairplay

R. t.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

- None -

MEDICAL CERTIFICATION

20. DATE OF DEATH

November - 11 - 1947 at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 10 (1947) to Nov. 11 (1947)

and that I last saw him alive on November 11 (1947)

Immediate cause of death

Uremia

Due to: Sepsis Peritonitis

By peritonitis

Due to:

G Generalized arteriosclerosis

Occlusive

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Lester Novenstein M.D.

M. D. or other

Address: Furbushard Rd. Date signed: 11-13-47

RECORDED

NOV 15 1947

STREAS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10429

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 43 years

Hospital, Institution, or street address where death occurred:

310 North Locust St.

How long in hospital or institution?

3. (a) FULL NAME

Leonard J. Saylor

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Mabel G. Saylor

7. Birth date of deceased (mo., day, yr.)

May 5, 1888

6.(c) If alive, give age

8. AGE:

Years
59Months
6Days
19

11 less than one day

hrs. min.

9. Birthplace

Franklin Co. Penna.

(Town, county, and state)

10. Usual occupation

Retired Policeman

11. Industry or business

MOTHER FATHER

Abraham R. Saylor

13. Birthplace

Penna.

14. Maiden name

Alice Bower

15. Birthplace

Wash. Co. Maryland

16. Informant

Mrs. Mabel G. Saylor

Address

310 N. Locust St. Hagerstown, Md.

17. Burial

Date thereof Nov. 26, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

Nov. 26, 1947

(Date rec'd by registrar)

B. G. Powers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

310 North Locust St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH

November 24, 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 9, 1947, to Nov. 24, 1947

and that I last saw her alive on Nov. 23, 1947

Immediate cause of death

Artificial Heart Disease

DURATION

2 yrs.

Due to

Due to

Other conditions

Artificial Heart Disease

2 yrs.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

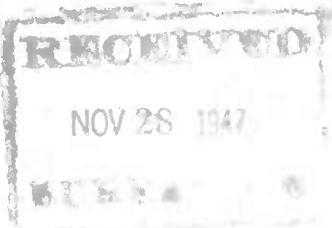
23. SIGNATURE

M. D. or other

Address

Date signed

F. J. Shuler
Hagerstown, Md. 11/26/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10430

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

2 week's

How long in above place of death?

Hospital, institution, or street address where death occurred:

421 Jefferson St.

How long in hospital or institution?

3. (a) FULL NAME

Sallie C. Semler

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed

John D. Semler

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 25, 1867

6.(c) If alive, give age years

8. AGE: Years Month Day If less than one day

80 - 27 hrs. min.

9. Birthplace Smithsburg Wash. Md.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

None

12. Name John Lum

13. Birthplace England

14. Maiden name Rachael Gaul

15. Birthplace Germany

16. Informant Mrs. Clyde Bowers

Address Hagerstown Md.

17. Burial

Date thereof 11-25-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Nov. 24, 1947, Mrs. Clyde Bowers,
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

D.C.

State County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

514 Quincy St. N.W.

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 22 1947 at 10:30 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 12 1947 to November 22 1947

and that I last saw h. E. alive on November 12 1947

Immediate cause of death Coronary occlusion

DURATION instantaneous

Due to Anteriosclerotic heart disease with hypertrophy 10 years

Due to (Patient was dead on arrival)

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

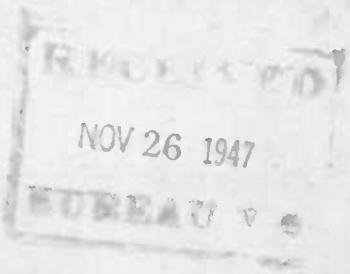
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

B. B. Semler M.D. or other

Address 148 W. Washington Street Date signed 11-24-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10431

Reg. Dist. No. 302

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Washington
County Hagerstown
City or town Unknown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred: 482 Mitchell Ave.

How long in hospital or institution?

3. (a) FULL NAME

Sally Shaffer

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Taylor Shaffer

7. Birth date of deceased (mo., day, yr.) December 31, 1870

8. AGE:	Years	Months	Days	If less than one day
	76	11	7	hrs. min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation None

11. Industry or business None

MOTHER FATHER David Pampell

13. Birthplace Woodstock Va.

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Berton T. Shaffer

Address Lancaster Pa.

Burial Burial

Date thereof 11-10-47

(Burial, cremation, or removal. Which?) Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. Nov. 9. 1947 Chas. Powers

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland Washington
City or town Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

Street No. 482 Mitchell Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 8 1947 at 7:40a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h. alive on 19. to 19.

and that I last saw h. alive on 19. to 19.

Immediate cause of death Vascular degeneration
Cerebral hemorrhage

Due to Chr. gomularia nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

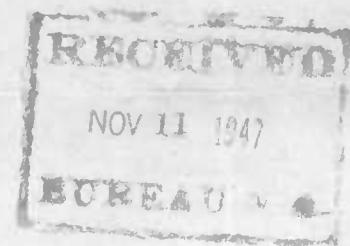
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE Robert Wells Deputy Adm. C. of Md.

M. D. or Dr.

Address Hagerstown Md. Date signed Nov. 9 '47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cause of death clearly and legibly. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10432

1228

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County WASHINGTON
City or town HAGERSTOWN

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 DAYS

Hospital, Institution, or street address where death occurred:

WASHINGTON COUNTY HOSPITAL

How long in hospital or institution? 11 DAYS

3. (a) FULL NAME

DORIS JEAN SHANK

3. (b) Social Security Number

None

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) APRIL 28 1939

8. AGE:

Years	Months	Days	If less than one day
8	6	23	hrs. min.

9. Birthplace

GREENCASTLE, FRANKLIN, PA.

(Town, county, and state)

10. Usual occupation

STUDENT

SCHOOL

11. Industry or business

ROSS SHANK

12. Name

SHADY GROVE, PA.

13. Birthplace

ETHEL D'REHL

14. Maiden name

GREENCASTLE, PA.

15. Birthplace

Ethel Shank

16. Informant

Greencastle, Pa.

Address

Burial Date thereof

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cem.

Location

Greencastle, Pa.

Address

Woodlawn Mortuary

(Date rec'd by registrar)

Nov. 20, 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County FRANKLIN

City or town GREENCASTLE

(If outside city or town limits, write RURAL and give nearest town)

Street No. 219 E. FRANKLIN ST.

(If rural, give LOCATION)

NON-VET ✓

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov. 21 1947 a.m.

Nov. 10 1947 Nov. 21 1947

and that I last saw her alive on Nov. 20 1947

Immediate cause of death

ACUTE CARDIAC FAILURE 1 DAY

Due to INTESTINAL OBSTRUCTION

FECAL.

Due to MEGA COLON (Hirschsprung's

DISEASE) CONGENITAL SINCE

6TH

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work

23. SIGNATURE

M. D. or other

Address 244 N. Potomac St. Date signed 11/21/47

RECEIVED

NOV 24 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

10433

170c

CERTIFICATE OF DEATH

Reg. Dist. No. 302

MY

1. PLACE OF DEATH:

County Washington
City or town Peters Town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 4 days

3. (a) FULL NAME

John Shatzley

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Lizzie Wright Shatzley

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

March 13, 1877

8. AGE:

70

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Franklin Co., Pa.

(Town, county, and state)

10. Usual occupation

Operator Secondhand Store

11. Industry or business

MOTHER FATHER

Simon Shatzley

13. Birthplace

Pennsylvania

MOTHER FATHER

Mary Boles

14. Maiden name

Pennsylvania

15. Birthplace

Mrs. Lizzie Shatzley

16. Informant

Address 773 S. 2nd St. Chambersburg,

17. Burial

Date thereof Nov. 8, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Lincoln Cemetery

Location

Chambersburg, Pa.

18. Funeral director

Parhur Funeral Home

Address

Chambersburg, Pa.

19. Date rec'd by registrar

Nov. 6, 1947

H. J. Bowers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Pennsylvania County Franklin

City or town Chambersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 773 S. 2nd St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 1947, at 8:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19... to 19...

and that I last saw him alive on

Immediate cause of death

Cerebral concussion

Multiple fractures of ribs

Due to Closed fracture rt. ulna

and femur

Due to Dislocation rt. foot

Shock

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accident Date of 11/3/47

Where did injury occur? Hagerstown Wash. D.C. (City or town) (State)

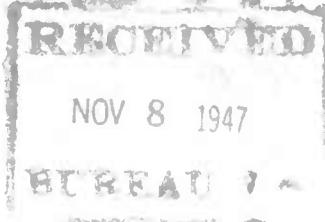
Injured at home, farm, industry, public place (where?) Middleburg Pike

Means of injury Auto collision Injured at work? No

23. SIGNATURE J. Robert Dello DEPUTY MEDICAL EXAM.

WASH. CO., MD. M. D. or

11/5/47 Date signed



PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. In case of death, physicians: please write the causes of death clearly and legibly. Is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10434

CERTIFICATE OF DEATH

1799

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

28 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1105 Hamilton Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

Mary M. Shervin

3. (b) Social Security Number

None

4. Sex

5. Color or race

8.(a) Single, married, widowed, or divorced

Female

White

Single

6.(b) Name of husband or wife

5.(c) If alive, give age

years

7. Birth date of deceased (mo. day, yr.)

October 31, 1872

8. AGE:

Years

Months

Days

If less than one day

75

0

1

hrs.

min.

9. Birthplace Lappans, Wash. Co., Md.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

12. Name Samuel E. Shervin

13. Birthplace Washington County, Md.

14. Maiden name Elizabeth Knodle

15. Birthplace Washington County, Maryland

16. Informant W. Hampton Shervin

Address Hagerstown, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 11-4-47

(month) (day) (year)

Rose Hill Cemetery

Cemetery or crematory

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

Nov. 4, 1947 - *Robert P. Conrad, M.D.*

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Nov 1

1947 at 11⁵⁵

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 23

1947

to Nov 1

1947

and that I last saw him alive on Nov 1

1947

Immediate cause of death

Eye burns of mouth & throat

DURATION

9 days

Due to Accidental swallowing of eye water

Due to

Broncho-pneumonia

9 days

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.

M. D. or other

Address Hagerstown, Md.

Date signed 11-3-47

DEPARTMENT OF STATE GRAYHAWK

U.S. GOVERNMENT PRINTING OFFICE: 1947 10-1200

CERTIFICATE OF DEATH

X GRAHAM

1. PLACE OF DEATH

2. DATE OF DEATH

3. TIME OF DEATH

4. PLACE OF BURIAL

5. DATE OF BURIAL

6. TIME OF BURIAL

7. GRAVESITE NUMBER

8. GRAVESITE ADDRESS

9. GRAVESITE CITY

10. GRAVESITE STATE

11. GRAVESITE ZIP CODE

12. GRAVESITE COUNTY

13. GRAVESITE TOWN

14. GRAVESITE STREET

15. GRAVESITE HOUSE NUMBER

16. GRAVESITE APARTMENT NUMBER

17. GRAVESITE NEIGHBORHOOD

18. GRAVESITE CITY

19. GRAVESITE STATE

20. GRAVESITE ZIP CODE

21. GRAVESITE COUNTY

22. GRAVESITE TOWN

23. GRAVESITE STREET

24. GRAVESITE HOUSE NUMBER

25. GRAVESITE APARTMENT NUMBER

26. GRAVESITE NEIGHBORHOOD

27. GRAVESITE CITY

28. GRAVESITE STATE

29. GRAVESITE ZIP CODE

30. GRAVESITE COUNTY

31. GRAVESITE TOWN

32. GRAVESITE STREET

33. GRAVESITE HOUSE NUMBER

34. GRAVESITE APARTMENT NUMBER

35. GRAVESITE NEIGHBORHOOD

36. GRAVESITE CITY

37. GRAVESITE STATE

38. GRAVESITE ZIP CODE

39. GRAVESITE COUNTY

40. GRAVESITE TOWN

41. GRAVESITE STREET

42. GRAVESITE HOUSE NUMBER

43. GRAVESITE APARTMENT NUMBER

44. GRAVESITE NEIGHBORHOOD

45. GRAVESITE CITY

46. GRAVESITE STATE

47. GRAVESITE ZIP CODE



RECEIVED BY THE U.S. GOVERNMENT PRINTING OFFICE FOR THE USE OF THE DEPARTMENT OF STATE
NOV 7 1947
BUREAU

SEARCHED INDEXED SERIALIZED FILED
NOV 7 1947
U.S. GOVERNMENT PRINTING OFFICE: 1947 10-1200

10435

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

104b

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

3. (a) FULL NAME

Araminta M. Shrader

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Nov. 12, 1915

8. AGE:

Years
31Months
11Days
30

If less than one day

hrs. min.

9. Birthplace

Greencastle, Franklin Co., Pa.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

MOTHER FATHER

12. Name John E. Shrader

13. Birthplace Greencastle, Pa.

14. Maiden name Ada G. Statler

15. Birthplace Upton, Pa.

16. Informant Mrs. Ada G. Williams

Address 37 N. Foundry St. Hagerstown, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Nov. 14, 1947

(month) (day) (year)

Cemetery or crematory

Rest Haven Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19. Nov. 13, 1947

(Date rec'd by registrar)

Staff, Bowers

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)Street No. 37 N. Foundry St.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

11 Nov

19 47 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 & Nov 19 47 to 11 Nov 19 47

and that I last saw her alive on 10 & Nov 19 47

Immediate cause of death

Cavernous sinus thrombosis
 Meningitis

DURATION

9 days 4 hrs
 9 days

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide...

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

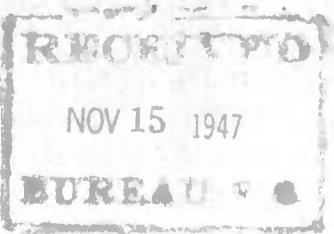
23. SIGNATURE

Eldon J. Heracham M.D.

M. D. or other

Address 16 Ogerton Rd. Date signed 12 Nov 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Dr. Brumback

10436

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55-*ext*

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington
 City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution? 3 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 407 Guilford Ave

(If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME

CHESTER MCKINLEY SMITH

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife Annie

7. Birth date of deceased (mo. day yr.) June 7 1898

8. AGE: Years Months Days If less than one day
49 4 29 hrs. min.9. Birthplace Myersville Fred Co. Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Md. Machine & Foundry Wks.

12. Name Oliver M. Smith

13. Birthplace Myersville Md.

14. Maiden name Annie Green

15. Birthplace Myersville Md.

16. Informant Mrs. Annie G? Smith

Address Hagers twon Md.

17. Burial Date thereof 11/8/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Vol. 8. 1947 Blackflower
(Date rec'd by registrar) Registrar

3.(b) Social Security Number

312-14-7695

MEDICAL CERTIFICATION

20. DATE OF DEATH November 6 1947 19. at 16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
6/18/47 19. to 11/6/47 19.and that I last saw him alive on 11/6/47 19.
Immediate cause of death Adeno Carcinoma right DURATION
parotid gland with general Uncertain
Metastasis. Involvement of brain.
Due to Carcinoma
saw first 6/18/47

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Same as above

Date of op. 8/28/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE L. H. Brumback

M. D. or

Date signed 11/8/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10437

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Washington Co. Hospital

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 18 days

3. (a) FULL NAME

Connie Mae Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F.

white Single

6. (b) Name of husband or wife:

7. Birth date of deceased (mo. day yr.) Nov. 4th 1947

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

18 hrs. min.

9. Birthplace Washington Co. Hospital

(town, county, and state)

10. Home town Hagerstown Md.

11. Industry or business

12. Name James C. Smith

MOTHER FATHER Wayneboro Pa

13. Birthplace Dorothea Balcoms

Hagerstown Md.

14. Maiden name

15. Birthplace

16. Informant James C. Smith

Address 644 N Locust St. City

17. Burial Date thereof Nov. 24th 1947

(Burial, cremation, or removal. Which?)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown Md.

18. Funeral director L. F. Peacher

Address Gunstowry Rd.

19. Date rec'd by registrar Nov. 24. 47

Blatt Powers

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. 644 N. Locust

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

7001

MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Nov 1947 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

4 Nov 1947 to 22 Nov 1947

and that I last saw h. & r. alive on 22 Nov 1947

Immediate cause of death

Pneumonia, bronchitis
(1st or 2nd day)

DURATION

6 days

Due to

Due to

Other conditions

Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

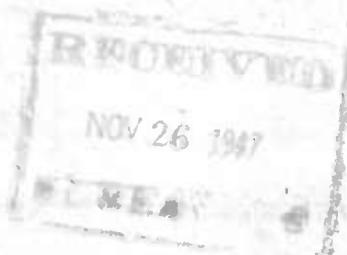
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Eldon & Howard M.D.

M. D. or other

Address Hagerstown Md. Date signed 11/25/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

928

CERTIFICATE OF DEATH

10438
301

Reg. Dist. No.

1. PLACE OF DEATH:
 Washington
 County.....
 City or town..... R.F.D. Sharpsburg RFD#1
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 Years
 Hospital, institution, or street address where death occurred:
 RFD #1 Sharpsburg
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 Maryland County Washington
 City or town RFD#1 Sharpsburg
(If outside city or town limits, write RURAL and give nearest town)
 Street No. RFD#1 Sharpsburg near dam #4
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife	Ralph Smith
7. Birth date of deceased (mo., day, yr.)	Feb. 11, 1911
8. (c) If alive, give age	35 years

8. AGE:	Years	Months	Days	If less than one day
36	8	25	hrs.	min.

9. Birthplace	Downsville, Washington, Maryland
(Town, county, and state)	

10. Usual occupation	Housewife
11. Industry or business	At home

12. Name	Don't Know
13. Birthplace	Don't Know

14. Maiden name	Effie Cline
15. Birthplace	Washington County, Maryland

16. Informant	Ralph Smith
Address	RFD#1 Sharpsburg, Maryland

17. Burial	Date thereof Nov. 9, 1947
(Burial, cremation, or removal. Which?)	

Cemetery or crematory	Greenlawn Cemetery
Location	Williamsport, Maryland

18. Funeral director	Edith V. Leaf
Address	Williamsport, Maryland

19. Nov. 9 1947	Mrs. E. Lee M. Elsey
(Date rec'd by registrar)	Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 6, 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/6/47 19... to 11/6/47 19... and that I last saw h. alive on Nov. 6, 1947.

Immediate cause of death Acute heart Failure

Due to Initial heart failure due to Rheumatic Endocarditis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE People Known M. D. or other

Address Willcox & Leaf Date signed 11/8/47

RECEIVED

NOV 12 1947

FBI - BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information given is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10439

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH:

County

Washington

Rural

City or town

Mt. Tena

Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, institution, or street address where death occurred

Boonsboro Route - 2

How long in hospital or institution?

at Home

3. (a) FULL NAME

Gelia Stouffer

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

Elmer

Stouffer

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

September - 28 - 1871

8. AGE:

Years

Months

Days

If less than one day

76

1

8

hrs.

min.

9. Birthplace

Mt. Tena Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

Dairy Home

MOTHER FATHER

12. Name

William Tura

13. Birthplace

Wash. Co. Md.

14. Maiden name

Catherine Sager

15. Birthplace

Wash. Co. Md.

16. Informant

Elmer Stouffer

Address

Boonsboro Md. R. 2

17. Burial

Date thereof Nov. 10. 1947
(Burial, cremation, or removal. Which?)
(month) (day) (year)

Cemetery or crematory

Mt. Tena Union Cemetery

Location

Mt. Tena Md.

18. Funeral director

Guy J. Best & Sons

Address

Boonsboro Md.

19. Nov. 9.

1947 John H. Dix
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Washington

City or town Mt. Tena - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Boonsboro Md. R. 2

(If rural, give LOCATION)

no.

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH November - 6 - 1947, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 29 1947, to 6 Mar 1947

and that I last saw her alive on 6 Mar 1947

Immediate cause of death

Pneumonia, bronchitis, etc. (if applicable)

DURATION

4 days

Due to

Due to

Other conditions

Hypertension

not known

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

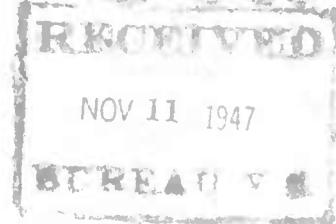
Injured at work?

23. SIGNATURE

John H. Dix

M. D. or other

Address Sergeant's Mtn. Date signed 8 Mar 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct spelling. Physicians: please write the causes of death clearly and legibly. Is especially important.

Dr. Conrad

10440

BC

Reg. Dist. No. 305

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Washington
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town) Breathedsville
 How long in above place of death? 8 Months
 Hospital, Institution, or street address where death occurred: Md. State reformatory for Males
 How long in hospital or institution? 8 Mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother) Maryland
 State..... County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town) Baltimore
 Street No. 710 So. Hanover St
 (If rural, give LOCATION) None
 2.(a) If veteran, name war. None

3. (a) FULL NAME

JAMES THORNTON

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife. --
 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) November 3 1930

8. AGE: Years Months Days It less than one day
 17 0 12 hrs. min.

9. Birthplace Baltimore City Maryland
 (Town, county, and state)

10. Usual occupation Porter

11. Industry or business Laborer

MOTHER FATHER 12. Name James Thornton Sr.

13. Birthplace Virginia

14. Maiden name Orphelia Coleman

15. Birthplace No. Carolina

16. Informant Records of Md. State Ref. for Males

Address Breathedsville Md.

17. Burial Date thereof 11/18/47
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Calvary Cemetery

Location Anne Arundel Co. Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. Nov. 15 1947 John H. Best
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14 1947 19 10.30

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 1947 to Nov 14 1947
 and that I last saw him alive on Nov 14 1947

Immediate cause(s) of death. Pulmonary Tuberculosis
 DURATION 4 mo.

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Mesne of injury Injured at work?

23. SIGNATURE Robert P. Conrad, M.D.

M. D. or other

Address Hagerstown, Md. Date signed 11-15-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information given is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

10441

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

County..... Washington
City or town..... Hagerstown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital
1 day

How long in hospital or institution?

3. (a) FULL NAME

Valerie Lynn Wade

4. Sex
Female5. Color or race
White6.(a) Single, married, widowed, or divorced
Single

6.(b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.) Nov. 2, 1947

8. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
14 hrs. min.9. Birthplace Martinsburg--West Virginia
(town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name..... Unknown

13. Birthplace

14. Maiden name Phyllis Wade

15. Birthplace Trego, Maryland

16. Informant Mr. Elmer Wade

Address Keedysville, Maryland

17. Burial Date thereof Nov. 18 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Locust Grove

Location Locust Grove--Md

18. Funeral director R. I. Earnshaw

Address Keedysville, Md

Nov. 17. 1947 Chester Powers
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Keedysville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 16 1947 at 4:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

17/16 1947 to 11/16 1947
and that I last saw her alive on 11/16 1947

Immediate cause of death

cerebral hemorrhage

DURATION

Due to

asphyxia

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. F. Bonner M.D.
M. D. or other

Address Hagerstown, Md Date signed 11/17/47

RECEIVED

NOV 19 1947

WILLIS

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10442

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH Washington
County Hagerstown
City or town (If outside city or town limits, write RURAL and give nearest town) 36 years
How long in above place of death?
Hospital, institution, or street address where death occurred: Washington County Hospital
How long in hospital or institution? 8 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Washington
City or town Hagerstown
Street No. 16 Berner Avenue
(If outside city or town limits, write RURAL and give nearest town)
(If rural, give LOCATION)

3. (a) FULL NAME Agnes Pearl Wolfensberger

3. (b) Social Security Number 215-18-2848

4. Sex Female Color or race White 5. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Silas D. Wolfensberger

7. Birth date of deceased (mo., day, yr.) July 9, 1911 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day
36 4 21 .hrs. min.

9. Birthplace Hagerstown- Wash. Co., Md.
(Town, county, and state)

10. Usual occupation Restaurant Employee

11. Industry or business

MOTHER FATHER 12. Name Lewis B. Mundey
13. Birthplace Washington County, Md.

MOTHER 14. Maiden name Josephine Loudenslager
15. Birthplace Washington County, Md.

16. Informant Silas D. Wolfensberger

Address 16 Berner Ave- Hagerstown, Md.

17. Burial Date thereof Dec 3 1947
(Burial, cremation, or removal. Which?)

Cemetery or crematory Rose Hill Cemetery
Location Hagerstown, Md.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Maryland

Dec 3 1947 Death record
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION
November 30, 1947

20. DATE OF DEATH November 30, 1947 at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 1-47 to Nov 30 1947

and that I last saw her alive on Nov 30-47 1947

Immediate cause of death

Cancer uterus

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

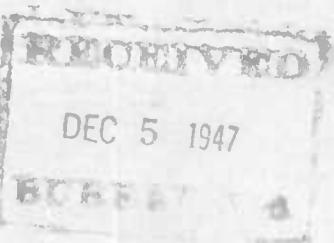
Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. D. Latty M. D. or other

Address Hagerstown, Maryland Date signed 11/1/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

10443

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH:

Washington
County.....Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Middleburg Pike

How long in hospital or institution?

3. (a) FULL NAME

Bruce G. Wolford

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Married

6.(b) Name of husband or wife Susie S. Wolford

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo. day, yr.) November 16, 1874

8. AGE: Years Months Days If less than one day
72 11 9 hrs. min.9. Birthplace Washington County, Maryland
(Town, county, and state)

10. Usual occupation Retired Laborer

11. Industry or business

12. Name William Wolford

13. Birthplace Fairview, Md.

14. Maiden name Cunningham

15. Birthplace Clearspring, Md.

16. Informant Mrs. Bruce G. Wolford

Address Hagerstown, Maryland

17. Burial Date thereof 11-10-47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Nov. 8. 47 Date rec'd by registrar

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. Middleburg Pike R.F.D.\$
(If rural, give LOCATION)

2.(a) If veteran, name war Spaniard American War

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

11/7 1947 at 40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

"11/7 1947 to "11/7 1947 and that I last saw him alive on "11/7 1947

Immediate cause of death

Chronic Sub Carditis arterio - Oclerosis

Due to 67

Due to 67

Other conditions ✓

(Include pregnancy within 3 months of death)

Major findings or operations ✓

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

Y. M. Miller

23. SIGNATURE

M. D. or other

Address Hagerstown, Md Date signed 11/7-47

WISCONSIN STATE DEPARTMENT OF HED

REG'D. NO. CHAS. S. GALLAGHER

CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. SURFACE ROLL

3. GROUND

4. GROUND

5. GROUND

6. GROUND

7. GROUND

8. GROUND

9. GROUND

10. GROUND

11. GROUND

12. GROUND

13. GROUND

14. GROUND

15. GROUND

16. GROUND

17. GROUND

18. GROUND

19. GROUND

20. GROUND

21. GROUND

22. GROUND

23. GROUND

24. GROUND

25. GROUND

26. GROUND

27. GROUND

28. GROUND

29. GROUND

30. GROUND

31. GROUND

32. GROUND

33. GROUND

34. GROUND

35. GROUND

36. GROUND

37. GROUND

38. GROUND

39. GROUND

40. GROUND

41. GROUND

42. GROUND

43. GROUND

44. GROUND

45. GROUND

46. GROUND

47. GROUND

48. GROUND

49. GROUND

50. GROUND

51. GROUND

52. GROUND

53. GROUND

54. GROUND

55. GROUND

56. GROUND

57. GROUND

58. GROUND

59. GROUND

60. GROUND

61. GROUND

62. GROUND

63. GROUND

64. GROUND

65. GROUND

66. GROUND

67. GROUND

68. GROUND

69. GROUND

70. GROUND

71. GROUND

72. GROUND

73. GROUND

74. GROUND

75. GROUND

76. GROUND

77. GROUND

78. GROUND

79. GROUND

80. GROUND

81. GROUND

82. GROUND

83. GROUND

84. GROUND

85. GROUND

86. GROUND

87. GROUND

88. GROUND

89. GROUND

90. GROUND

91. GROUND

92. GROUND

93. GROUND

94. GROUND

95. GROUND

96. GROUND

97. GROUND

98. GROUND

99. GROUND

100. GROUND

101. GROUND

102. GROUND

103. GROUND

104. GROUND

105. GROUND

106. GROUND

107. GROUND

108. GROUND

109. GROUND

110. GROUND

111. GROUND

112. GROUND

113. GROUND

114. GROUND

115. GROUND

116. GROUND

117. GROUND

118. GROUND

119. GROUND

120. GROUND

121. GROUND

122. GROUND

123. GROUND

124. GROUND

125. GROUND

126. GROUND

127. GROUND

128. GROUND

129. GROUND

130. GROUND

131. GROUND

132. GROUND

133. GROUND

134. GROUND

135. GROUND

136. GROUND

137. GROUND

138. GROUND

139. GROUND

140. GROUND

141. GROUND

142. GROUND

143. GROUND

144. GROUND

145. GROUND

146. GROUND

147. GROUND

148. GROUND

149. GROUND

150. GROUND

151. GROUND

152. GROUND

153. GROUND

154. GROUND

155. GROUND

156. GROUND

157. GROUND

158. GROUND

159. GROUND

160. GROUND

161. GROUND

162. GROUND

163. GROUND

164. GROUND

165. GROUND

166. GROUND

167. GROUND

168. GROUND

169. GROUND

170. GROUND

171. GROUND

172. GROUND

173. GROUND

174. GROUND

175. GROUND

176. GROUND

177. GROUND

178. GROUND

179. GROUND

180. GROUND

181. GROUND

182. GROUND

183. GROUND

184. GROUND

185. GROUND

186. GROUND

187. GROUND

188. GROUND

189. GROUND

190. GROUND

191. GROUND

192. GROUND

193. GROUND

194. GROUND

195. GROUND

196. GROUND

197. GROUND

198. GROUND

199. GROUND

200. GROUND

201. GROUND

202. GROUND

203. GROUND

204. GROUND

205. GROUND

206. GROUND

207. GROUND

208. GROUND

209. GROUND

210. GROUND

211. GROUND

212. GROUND

213. GROUND

214. GROUND

215. GROUND

216. GROUND

217. GROUND

218. GROUND

219. GROUND

220. GROUND

221. GROUND

222. GROUND

223. GROUND

224. GROUND

225. GROUND

226. GROUND

227. GROUND

228. GROUND

229. GROUND

230. GROUND

231. GROUND

232. GROUND

233. GROUND

234. GROUND

235. GROUND

236. GROUND

237. GROUND

238. GROUND

239. GROUND

240. GROUND

241. GROUND

242. GROUND

243. GROUND

244. GROUND

245. GROUND

246. GROUND

247. GROUND

248. GROUND

249. GROUND

250. GROUND

251. GROUND

252. GROUND

253. GROUND

254. GROUND

255. GROUND

256. GROUND

257. GROUND

258. GROUND

259. GROUND

260. GROUND

261. GROUND

262. GROUND

263. GROUND

264. GROUND

265. GROUND

266. GROUND

267. GROUND

268. GROUND

269. GROUND

270. GROUND

271. GROUND

272. GROUND

273. GROUND

274. GROUND

275. GROUND

276. GROUND

277. GROUND

278. GROUND

279. GROUND

280. GROUND

281. GROUND

282. GROUND

283. GROUND

284. GROUND

285. GROUND

286. GROUND

287. GROUND

288. GROUND

289. GROUND

290. GROUND

291. GROUND

292. GROUND

293. GROUND

294. GROUND

295. GROUND

296. GROUND

297. GROUND

298. GROUND

299. GROUND

300. GROUND

301. GROUND

302. GROUND

303. GROUND

304. GROUND

305. GROUND

306. GROUND

307. GROUND

308. GROUND

309. GROUND

310. GROUND

311. GROUND

312. GROUND

313. GROUND

314. GROUND

315. GROUND

316. GROUND

317. GROUND

318. GROUND

319. GROUND

320. GROUND

321. GROUND

322. GROUND

323. GROUND

324. GROUND

325. GROUND

326. GROUND

327. GROUND

328. GROUND

329. GROUND

330. GROUND

331. GROUND

332. GROUND

333. GROUND

334. GROUND

335. GROUND

336. GROUND

337. GROUND

PLEASE WRITE PLAINLY, WITH UNEVEN INK. Supply every item of information carefully. Inexact or illegible entries will be disregarded. Physicians: please write the causes of death clearly and legibly; it is especially important.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10444

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH:

County Washington
City or town Hagerstown, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

Potomac Hills

How long in hospital or institution?

3. (a) FULL NAME

Harry L. Yingling

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Widower

6.(b) Name of husband or wife Goldie Yingling

7. Birth date of deceased (mo., day, yr.) July 3, 1875

8. AGE: Years 72 Months 4 Days 2 It less than one day hrs. min.

9. Birthplace Westminster, Maryland

(Town, county, and state)

10. Usual occupation Yingling Auto Sales & Service

11. Industry or business

12. Name Ezra Yingling

13. Birthplace Westminster, Maryland

14. Maiden name Anna Marshall

15. Birthplace Westminster, Maryland

16. Informant Maxwell Yingling

Address Hagerstown, Maryland

17. Burial Date thereof 11-7-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rest Haven Cemetery

Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons

Address Hagerstown, Maryland

19. Date rec'd by registrar Nov. 6, 1947

19.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Potomac Hills

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH Nov. 5

19 47 at 2:30A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-18-47 to 11-5-47

and that I last saw him alive on 11-4-47

19

Immediate cause of death

Myocardial Dystrophy

DURATION

6 hrs

Due to: Arteriosclerosis
Heart Disease & Anginal
Syndrome

4-5 yrs

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of...

Where did injury occur?

(City or town) (County)

(State)

Injured at home, farm, industry, public place (where?)

Mesne of injury

Injured at work?

23. SIGNATURE..... Dalton J. W. Welty M.D.

M. D. or other

Address 998 Potomac Ave.

Date signed 11-5-47

MARLBOROUGH STATE DEPARTMENT OF HHS

1947, CHAP. 61, Session Law

CERTIFICATE OF DEATH

SUPERIOR RECORD

Q. 1. Name
John Doe
Age 30
Sex Male
Color Brown
Signature John Doe

1. PLACE OF DEATH

Obituary

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

This person died in this state during the year 1947.

Cause of death: Natural death.

RECORDED

NOV 8 1947

SCREDAU